

# From the Editor

## Paying for the Right Stuff



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As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in Geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as an American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages*, *LTC Interface*, *Jefferson's Health Policy Newsletter*, *The Journal of Quality Healthcare*, and *Assisted Living Consult*.

Dr. Stefanacci is also founder and member of the board of directors of [www.Go4TheGoal.org](http://www.Go4TheGoal.org).

It's hard not to sound like a broken record or scratched CD—or to be even more current—faulty iPod hard drive. The repeating message that all too often is lost is that the Centers for Medicare and Medicaid Services (CMS) is firmly focused on the “pay” out. In fact the two catch phrases firmly planted throughout the hallways of CMS are “pay for performance” and “payment following patients.” Obviously the common thread is “pay” outs. Whether that be pay outs for providers through delivering superior outcomes or the pay out of benefits specific to a patient's needs—the common thread remains pay outs. But what exactly should Medicare be paying for to achieve better outcomes for our senior patients?

### Pay for Performance

Despite the poor update of physician participation in the first round of the Physician Quality Reporting Initiative (PQRI), CMS continues its commitment to paying for outcomes rather than paying on a volume basis. You will recall that a section of the Tax Relief and Health Care Act of 2006, Sec 101 Physician Payment and Quality Improvement, introduced the beginning of pay-for-performance initiatives within Medicare. The first round of the PQRI program started on July 1, 2007, and ended December 31, 2007. In this round providers received an additional 1.5% from Medicare for reporting measures identified as 2007 physician quality measures.

The 2008 PQRI identifies 119 measures, thus providing an additional 43 measures over the 74 measures utilized in 2007.<sup>1</sup> Also in preparation for testing of electronic health records (EHRs), based on reporting during 2008, 5 of the PQRI measures proposed for 2008 have been specified for EHR-based submission. These 5 measures are also included as measures used by the Doctor's Office Quality–Information Technology (DOQ-IT) project that was launched nationally in 2005. But despite these changes to the PQRI, many physicians have yet to embrace EHRs.

### Payment Following Patients

Yet another pay out focus of CMS is centered around the belief that payments or benefits should be based on a patient's needs, not on location of care. As a result, the differentiation that previously existed along facility lines will be eliminated.



For example, currently Medicare Part D dually eligible (those beneficiaries with both Medicare and Medicaid) have no copayments for their medications if they reside within a skilled nursing facility (SNF). At the same time, a nursing home-eligible patient outside the SNF is required to pay copayments for medications despite having the same exact needs. Currently there is legislation pending that would eliminate this disparity in a move to ensure that the payment follows the patient rather than being facility specific. It is likely that additional legislation and regulations will be developed to eliminate disparities that are based solely on location of care rather than a patient's needs.

### What We Should Be Paying For

As Medicare struggles to provide pay outs that motivate a system toward improved outcomes, legislators look to examine models of care that could serve as a model for the future. Such is the case with the Geriatric Assessment and Chronic Care Coordination Act (GACCCA). An examination of the evidence regarding the benefits of the measures called for in the GACCCA with its focus on the promotion of geriatric care principles—especially coordination of care—are found to most closely resemble those same principles found in the Evercare program. Evercare, a division of UnitedHealth Group, coordinates health care and well-being services for frail elderly, chronically ill, and disabled persons in the home, the community, and SNFs. Started in 1987, Evercare now serves more than 100,000 people nationwide through a variety of Medicaid, Medicare, and private-

pay health plans. As a result of the successes of the Evercare program, Evercare served as a key precedent for the Special Needs Plans (SNP) created under the Medicare Modernization Act of 2003.

The cost savings in Medicare expenditures from the application of the geriatric care principles—especially coordination of care—found in the GACCCA occur in the following areas:

#### Medicare Part A (Hospital Insurance)

- Reduction in emergency department (ED) visits
- Reduction in hospitalizations

#### Medicare Part B (Medical Insurance)

- Reduction in specialty services
- Reduction in diagnostic studies

#### Medicare Part D (Prescription Benefit)

- Reduction of adverse drug events
- Elimination of inappropriate medications
- Optimization of medication use through efficient prescribing

Research demonstrates that the geriatric care principles, especially care coordination, found in GACCCA, as applied by Evercare's approach to care, result in greater access to medical and nonmedical services, better health outcomes, and lower cost to the government.

- Professional teamwork among healthcare workers and continuity of care have been shown to help prevent some problems before they become serious: reducing hospitalizations for SNF residents by 45% and ED visits by 50%.<sup>2</sup>
- SNF patients in the Evercare program were seen more by their physicians than their peers enrolled in other plans. While they were hospitalized half as often as their counterparts, Evercare enrollees were more satisfied that they would be hospitalized when necessary.<sup>2</sup>

Through the Texas STAR+PLUS program, Evercare helped reduce hospitalizations by 22% and ED visits by 38%. More than 90% of enrollees said they were satisfied with their care coordinators.<sup>2</sup>

The Evercare STAR+PLUS healthcare plan was launched by the State of Texas in 1998 in Harris County as a pilot program and now serves approximately 65,000 members in that county. The program combines health and long-term care (LTC) services to elderly people and those with disabilities. The Texas Health and Human Services Commission recently approved

STAR+PLUS for expansion into an additional 28 Texas counties. The commission found that the program is saving the state government millions in healthcare costs while also providing efficient and effective care.<sup>3</sup>

Evercare's mission is to provide members with personalized service coordination. Service coordinators work with each member, creating a customized, holistic care plan that factors in a member's medical and nonmedical needs. The service coordinator arranges services that include respite care, food delivery, and transportation. The coordinator also monitors the member's health status and regularly communicates with primary care physicians, family members, and caregivers to ensure integrated, high-quality care.<sup>3</sup>

Prevention is a key aspect of Evercare's approach. The program helps its members receive preventive services such as immunizations, annual physicals, and flu shots, and includes extra benefits such as eyeglass coverage and dental services.<sup>3</sup>

An educational program called CareCheck offers help to those with chronic disorders such as diabetes and congestive heart failure. HomeCheck is an Evercare program that brings the primary care physician and other services to the member in his or her own home.<sup>3</sup>

Other states have seen improvements in health outcomes through programs like Evercare:

- More than 60% of elderly and physically disabled individuals enrolled in the Arizona Long Term Care System programs, beginning in 1989, were able to remain in their communities, compared to 5% at the program's start.<sup>2</sup>
- Persons enrolled in Florida's Nursing Home Diversion programs were 9 times less likely to enter SNFs for an extended stay than those who were not enrolled in these plans.<sup>2</sup>

## What's Next?

Despite the benefits of moving to a system that is based on quality outcomes and needs rather than volume and specific facilities, some programs are caught up in attempts to achieve perfection from the start. For example, the quest to implement sophisticated integrated technology systems to improve outcomes should not replace other needed changes. The Texas STAR+PLUS program reaped savings of \$123 million over 2 years, plus improved patient satisfaction, and it was done with a paper-based system. These savings demonstrated under the STAR+PLUS program only

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represent Medicaid savings.<sup>3</sup>

In addition, groups that have focused on transitions from hospital to home through "care transition interventions" have realized significant benefits. Typically these active "care transition interventions" focus on 4 entities: (1) medication self-management; (2) patient-centered records; (3) primary care and specialist follow-up; and (4) knowledge of "red flags" indicative of a worsening condition. Clearly much work needs to be done to improve our outcomes, so let's not wait around for the perfect solution while the system fails to delivery on results already achieved through relatively small changes.

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## References

1. Centers for Medicare and Medicaid Systems (CMS). 2008 PQRI Information. CMS Web site. [www.cms.hhs.gov/PQRI/35\\_2008PQRIInformation.asp](http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp). Accessed November 28, 2007.
2. Evercare reaches 100,000 enrollees across 35 states [press release]. June 26, 2006. Evercare Web site. [http://www.evercarehealthplans.com/press\\_release3.jsp](http://www.evercarehealthplans.com/press_release3.jsp). Accessed December 4, 2007.
3. Evercare expands Star+Plus offerings to 22 counties in Texas [press release]. July 19, 2006. Evercare Web site. [http://www.evercarehealthplans.com/press\\_release2.jsp;jsessionid=I1KOEIMEKHPJ](http://www.evercarehealthplans.com/press_release2.jsp;jsessionid=I1KOEIMEKHPJ). Accessed December 4, 2007.