Medicare Minutes

Medicare's Care Transitions Project

Medicare's Quality Improvement Organization (QIO) contractors are launching initiatives across the country to improve coordination across the continuum of health care. As part of the Care Transitions Project, QIOs are promoting seamless transitions to and from hospital care, home and primary care, skilled nursing care, or home health care.

The business case for the Care Transitions Project is clear: the process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid Services (CMS) measures.

To address this, the Care Transitions Project focuses on reducing unnecessary readmissions to hospitals that may increase risk or harm to patients and cost to Medicare. CMS is looking to QIOs to implement projects that effect process improvements to address issues in medication management, post-discharge follow-up, and plans of care for patients who move across health care settings.

"Our data show that nearly one in five patients who leave the hospital today will be readmitted within the next month, and that more than three-quarters of these readmissions are potentially preventable," said CMS Acting Administrator Charlene Frizzera. "This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how all of the members of an area's health care team can better work together in the best interests of their shared patient population."

"The Care Transitions Project is a new approach for CMS," said Barry M. Straube, MD, chief medical officer for CMS and its Office of Clinical Standards and Quality director. "Rather than focusing on one global problem and trying to apply a one-size-fits-all solution across the country, Care Transitions experts will look in their own backyards to learn why hospital re-admissions occur locally and how patients transition between health care settings. Based on this community-level knowledge, Care Transitions teams will design customized solutions that address the underlying local drivers of re-admissions."

Each of the Care Transition communities is led by a state Quality Improvement Organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers, and stakeholder groups to refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value health care they deserve. Each QIO in the project is required to work with partners to implement the following:

- Hospital and community system-wide interventions
- Interventions that target specific diseases or conditions
- Interventions that target specific reasons for admission

This innovative project was launched in 14 sites across the country in August 2008. Participating communities are: western PA; southern NJ; northwest Denver, CO; Miami, FL; Harlingen, TX; Greater Lansing area, MI; Whatcom County, WA; metro Omaha, NE; Baton Rouge, LA; Tuscaloosa, AL and surrounding areas; Providence RI; Evansville, IN; Metro Atlanta East, GA; and Upper Capitol Region, NY.

To learn more about the Care Transitions Project and the QIO Program, please visit http://www.qualitynet.org/medqic.

E-Prescribing Incentives

Eligible professionals who successfully report an E-prescribing measure to CMS in 2009 could receive an incentive payment equal to 2% of all of their Medicare Part B fee-for-service allowed charges for services furnished during this calen-

dar year. There is no sign-up or preregistration to participate in the E-Prescribing Incentive Program.

For the 2009 E-prescribing reporting year, to be a successful E-prescriber and to receive an incentive payment, an eligible professional (EP) must report one E-prescribing measure in at least 50% of the cases in which the measure is reportable by the eligible professional during 2009.

However, there are certain limitations for participation. First, eligible professionals must have and use a qualified E-prescribing system. Second, at least 10% of eligible professionals' Medicare Part B–covered services must be made up of codes that appear in the denominator of the E-prescribing measure.

To help eligible professionals navigate the new Incentive Program, CMS has added new educational material to its library of online resources. The "2009 E-Prescribing Incentive Program Made Simple" is a step-by-step guide to help eligible professionals determine their eligibility to participate in the E-prescribing incentive program and to walk eligible professionals through the E-prescribing process.

To access this new educational product, as well as all available E-Prescribing educational resources, visit http://www.cms.hhs.gov/PQRI and click on the Electronic Prescribing Incentive Program tab. Once on the E-Prescribing page, scroll down to the "Downloads" section and click on the "2009 Electronic Prescribing Incentive Program Made Simple" link. Check the site often for more updates about the program.

2009 Physician Quality Reporting Initiative Program Update

CMS has posted two additional resource documents for providers participating in the Physician Quality Reporting Initiative (PQRI) Program. The following resources were discussed during the February 18, 2009, National Provider Call hosted by CMS, and are available at www.cms.hhs.gov/PQRI.

January 1, 2008–September 30, 2008 Aggregate Quality Data Code (QDC) Error Report: This report contains aggregate-level information about the quality data codes submitted between January 1, 2008, through September 30, 2008, by measure, for the PQRI program. This information is available as a downloadable document on the "Analysis and Payment" section page in the "Downloads" section.

Status Update regarding CPT II Coding Issue for the 2009 PQRI: This report gives an update regarding a recently identified CPT II coding issue, which affected several QDCs used for reporting a number of quality measures through the claims-based reporting method for 2009 PQRI. For information and guidance regarding this issue, please see the downloadable document on the "Measures/Codes" section page in the "Downloads" section.

Medicare to Become Test Lab for US Health Care System Changes

During an April US Senate Finance Committee meeting, Glenn Steele, president of the Geisinger Health System in Danville, Pennsylvania, touted Medicare as a system that could help lead change in the US health care system. "I think the leverage is in Medicare," Steele said, pointing out that reform efforts should focus on patients with costly chronic conditions who do not always receive good quality care or continuity of care. Steele argued that Medicare should be given flexibility to innovate and test various models of payments.

According to Democratic Sen Max Baucus of Montana, Medicare is going to be "the driver" for quality improvements in the US health care system. This is because private insurers follow Medicare policies. The new approach, according to the committee, will stress close follow-up care for seniors by doctors and nurses to help keep chronically ill patients from having to be hospitalized over and over.

CMS Expands Coverage for PET Scans

CMS issued a final national coverage determination that expands coverage for initial testing with positron emission tomography (PET) scan of Medicare beneficiaries diagnosed with and treated for most solid tumor cancers. The change is based on data collected through the Coverage with Evidence Development (CED) program that showed a favorable effect of PET scans on physician treatment decisions. According to CMS, this decision is the first time that the agency has reconsidered a coverage policy based on new evidence developed under the CED program. MPM