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# Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States

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Hospitalizations can be disruptive and risky for nursing facility residents and costly for Medicare and Medicaid. In 2009, an estimated 26 percent of hospitalizations for all fee-for-service (FFS) Medicare-Medicaid enrollees were potentially avoidable by preventing or treating their conditions outside of a hospital.<sup>1</sup> Among Medicare-Medicaid enrollees, potentially avoidable hospitalizations from nursing facilities are much more common than hospitalizations from other settings. In 2009, the rate of potentially avoidable hospitalizations in all settings combined was 133 per 1,000 person-years, while the rate was 285 per 1,000 person-years in longer-term Medicaid-paid nursing facilities, and 690 per 1,000 person-years in short-term Medicare-paid skilled nursing facilities (SNFs).<sup>2,3</sup> Total Medicare and Medicaid costs for potentially avoidable hospitalizations in all settings for Medicare-Medicaid enrollees in 2009 were \$5.4 billion, with an average cost of \$8,783 per hospitalization.<sup>4</sup> The rate of potentially avoidable hospitalizations varies widely across states.<sup>5</sup>

**IN BRIEF:** States that contract with health plans to provide comprehensive Medicare and Medicaid services for dually eligible enrollees in nursing facilities can work with these plans to reduce avoidable hospitalizations. Since the health plans are fully responsible for Medicare hospital, physician, skilled nursing facility, and prescription drug services, as well as Medicaid long-term nursing facility services, they have financial incentives and many of the tools needed to reduce avoidable hospitalizations. In contracting with health plans, states can promote efforts to reduce avoidable hospitalizations through contract requirements, performance incentives, and performance improvement projects. Health plans themselves, with encouragement and support from states, can use the tools they have to work with nursing facilities, hospitals, physicians, pharmacists, enrollees, and their families to achieve that goal. States can lay a firmer groundwork for this by making changes in Medicaid fee-for-service nursing facility payment systems to reduce incentives for hospitalizations.

Because Medicare pays for almost all hospital services for Medicare-Medicaid enrollees, while Medicaid pays for most long-term nursing facility services, both Medicare and Medicaid currently have incentives and opportunities to shift care settings and thus costs to the other payer.<sup>6</sup> In the FFS system, Medicare pays for almost all of the costs of avoidable hospitalizations for Medicare-Medicaid enrollees (96 percent in 2009).<sup>7</sup> If Medicare-Medicaid enrollees in a Medicaid nursing facility are treated in the facility rather than being transferred to a hospital, Medicaid must pay the nursing facility costs.

## State Options to Reduce Avoidable Hospitalizations

Medicaid was the primary payer for nursing facility services for nearly two-thirds of nursing facility residents in 2011, almost 90 percent of whom were dually eligible for Medicare and Medicaid.<sup>8</sup> While this gives states substantial responsibilities for the care provided in these facilities, Medicaid agencies have only limited tools to reduce avoidable hospitalizations for dually eligible residents since their hospital, physician, and prescription drug services are all paid for by Medicare. States do, however, have some options for reducing these hospitalizations in both capitated managed care and fee-for-service (FFS) Medicaid programs.

Integrating responsibility for Medicare and Medicaid services in a capitated managed care model allows the creation of incentives to both improve care and reduce expenditures for Medicare-Medicaid enrollees in nursing facilities. In this model, the savings from avoidable hospitalizations can be used to pay for enhanced services in the nursing facility that may reduce the need for hospitalizations, and there is a single responsible entity with information on all the services that are being provided to Medicare-Medicaid enrollees in the facility.

While states have fewer tools to reduce avoidable hospitalizations for Medicare-Medicaid enrollees in a FFS system, states can make modifications to Medicaid FFS reimbursement for nursing facilities that would reduce the incentives for avoidable hospitalizations for Medicaid-only enrollees in FFS programs. These modifications to the Medicaid FFS reimbursement system – the usual starting point for health plan and nursing facility reimbursement negotiations – would also facilitate health plan efforts to reduce hospitalizations for Medicare-Medicaid enrollees. This technical assistance brief outlines the options available to states in both capitated and FFS arrangements.

## Capitated Managed Care Options

The Centers for Medicare & Medicaid Services (CMS) and many states are focusing on reducing potentially avoidable hospitalizations for nursing facility residents.<sup>9,10</sup> States participating in the CMS financial alignment demonstrations using the capitated model have the greatest potential to reduce avoidable hospitalizations for nursing facility residents, since the Medicare-Medicaid Plans (MMPs) they are contracting with are fully at risk for both Medicare and Medicaid services, and therefore have significant financial incentives to reduce the use of costly Medicare hospital services. They also have direct contractual relationships with the hospitals and nursing facilities whose cooperation is needed to reduce avoidable hospitalizations.

States that contract with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to cover Medicaid nursing facility services have similar opportunities. However, the degree of integration of responsibility for all Medicare and Medicaid services within single accountable health plans varies among the states using this approach.<sup>11</sup>

The capitated model itself gives health plans the financial incentive and many of the tools needed to reduce avoidable hospitalizations from nursing facilities. Hospitalizations are costly alternatives for health plans, and when plans pay for hospital, physician, prescription drug, and nursing facility services they have some ability to influence the behavior of those service providers. Following are three options that states and health plans can use to increase and strengthen the incentives and tools inherent in managed care models:

### 1. Include performance measures in health plan contracts.

States can include potentially avoidable hospitalizations for nursing facility residents as a performance measure in their contracts with health plans, especially those that have responsibility for hospital services, like MMPs and D-SNPs. Performance measures can be tied to health plan payment, assignment of new enrollees, health plan report cards, contract renewal, and other consequences important to health plans.

States participating in capitated model financial alignment demonstrations incorporated a range of quality and performance measures in their MOUs with CMS that were subsequently included in three-way contracts among CMS, states, and MMPs.<sup>12</sup> None of the measures focuses directly on reducing potentially avoidable hospitalizations from nursing facilities, but several could move MMPs in this direction. States contracting with D-SNPs for coverage of Medicaid nursing facility services could also use these or similar measures. States contracting with D-SNPs may have more flexibility in amending their contracts to include new measures, since their contracts can be modified every year, while the three-way contracts between states, CMS, and MMPs are less amenable to change over the three-year life of the demonstrations. Following are examples of MMP measures, the first three of which are used by all the states implementing capitated model demonstrations:<sup>13</sup>

- **Plan all-cause readmissions within 30 days.** Although it does not focus specifically on readmissions for nursing facility residents, those readmissions are included in the measure.
- **Percent of long-stay, high-risk nursing facility residents with pressure ulcers.** Severe pressure ulcers are a common cause of hospital admissions.
- **Percent of plan members using high-risk medications.** This measure applies to the Medicare Part D drugs that MMPs are responsible for providing for all members, including those in nursing facilities.

- **Percent of nursing facility residents experiencing major falls with a major injury.** New York is planning to use this measure, which focuses on another common cause of hospital admissions.
- **Nursing facility urinary tract infection hospital admission rate.** Illinois is using this as a nursing facility performance measure.
- **Emergency department utilization rate.** California is including this measure, and is potentially revising it to reflect avoidable visits. It would apply to emergency department visits for all MMP enrollees, not just those in nursing facilities.

## 2. Focus health plan performance and quality improvement projects.

States can require Medicaid health plans to work with the state's External Quality Review Organization (EQRO) to conduct performance improvement projects in specific areas, which could include reduction of avoidable hospitalizations from nursing facilities.<sup>14</sup> Medicare Advantage plans have a similar requirement to conduct quality improvement projects, working with CMS and Medicare Quality Improvement Organizations (QIOs).<sup>15</sup>

States that contract with MMPs and D-SNPs to cover both Medicare and Medicaid services can work with CMS, QIOs, state EQROs, and the health plans to coordinate performance and quality improvement projects so that they focus on the same topics at the same time, minimizing burdens on the health plans and enhancing the potential impact of projects that involve both Medicare and Medicaid services. Reducing avoidable nursing facility hospitalizations would be a solid candidate for such joint projects.

## 3. Encourage and facilitate specific health plan efforts.

MMPs participating in financial alignment demonstrations and D-SNPs contracting with states to cover Medicaid nursing facility services have a range of tools available to reduce avoidable hospitalizations that states can encourage them to use.

This summary of potential health plan actions is based in part on discussions in March and April of 2014 between Integrated Care Resource Center (ICRC) staff and representatives of health plans in Arizona, Minnesota, and Massachusetts with many years of experience in providing Medicaid nursing facility and other Medicare and Medicaid services to Medicare-Medicaid enrollees. ICRC also spoke with representatives from an organization participating in a current CMS initiative to reduce avoidable nursing facility hospitalizations in a FFS setting. Based on these interviews, some actions that health plans could take, with state encouragement, include:

- **Waiving the requirement for three-day inpatient hospital stay to qualify for SNF-level reimbursement.** Traditional FFS Medicare requires a three-day inpatient hospital stay before it will cover a SNF stay, and each beneficiary is limited to up to 100 days of SNF care following the hospital discharge. This can give a Medicaid nursing facility a financial incentive to send a beneficiary to the hospital and then receive reimbursement from Medicare at the higher SNF rate after the beneficiary is discharged and returns to the facility. Such hospitalizations can also result in a financial benefit for the state because Medicaid is responsible only for beneficiary deductibles and coinsurance for Medicare-covered hospital and SNF services, plus whatever Medicaid bed-hold payments the state may make to the nursing facility.<sup>16</sup> However, health plans may choose to waive this three-day inpatient stay requirement, depending on the member's care needs. All three plans that ICRC interviewed waive this three-day requirement, with one noting that it uses Milliman Care Guidelines when making that decision.<sup>17</sup> States could encourage health plans to waive the three-day stay requirement as a way of increasing facility incentives to treat the resident in place when staff have the clinical and technical capability to do so, thereby preventing avoidable hospitalizations.<sup>18</sup> Minnesota currently requires D-SNPs participating in the state's Minnesota Senior Health Options program for elderly Medicare-Medicaid enrollees to waive the requirement.<sup>19</sup> CMS regulations explicitly allow Medicare Advantage plans to waive the three-day inpatient hospital stay requirement, and CMS reports that 95 percent of non-employer Medicare Advantage plans have elected to do so.<sup>20</sup>
- **Making greater use of nurse practitioners (NPs) in nursing facilities.** In a qualitative study of reasons for hospitalization from long-term care, limited on-site capacity at the facility to address medical issues was cited as a primary factor driving many hospitalizations.<sup>21</sup> To address this, states could encourage or require health plans to use NPs in nursing facilities. The Evercare model, a managed care approach using NPs, has been

shown to reduce avoidable hospitalizations by allowing more complex care to be managed in nursing facilities.<sup>22</sup> Representatives interviewed by ICRC from two of three plans that have provided Medicare and Medicaid services for Medicare-Medicaid enrollees in nursing facilities for several years reported that they use NPs extensively, typically employing NPs who provide daily on-site care and on-call care. One plan reported that when a resident is about to be sent to the emergency department (ED), the NPs call the ED to explain the care that can be provided in the nursing facility in case such treatment can avoid a hospitalization. Another plan commented that hospitals are “dangerous” for frail elders, so after a resident is hospitalized, the plan’s NP calls the hospitalist to discuss the situation, including concerns families may have, what technical care the nursing facility can and cannot provide, and the potential need for help with palliative care.

- **Encouraging more appropriate prescription drug use.** The higher the number of medications nursing facility residents take, the higher their risk of potentially avoidable hospitalizations.<sup>23</sup> Incentives for Part D plans, managed care plans, and nursing facilities to optimize drug use can be created within or outside of capitation, although including nursing facility services in a capitated managed model gives health plans greater leverage over these facilities.<sup>24-26</sup> Following are three strategies to encourage more appropriate prescription drug use:
  - **Medication therapy management (MTM) programs.** MMPs, D-SNPs, and other Medicare health plans that cover Part D drugs are required to have MTM programs that focus on high-need, high-cost users of prescription drugs, including residents of nursing facilities.<sup>27</sup> MTM programs require health plans to provide targeted interventions for both beneficiaries and prescribers, quarterly targeted medication reviews, and an annual written comprehensive medication review. MMPs and D-SNPs could use these MTM programs as a way of developing collaborative and ongoing relationships with nursing facilities and their consultant pharmacists to improve medication use.
  - **Use of independent consultant pharmacists.** MMPs and D-SNPs can hire or contract with independent pharmacists to review the work of nursing facility consultant pharmacists, who are usually employed by the pharmacy that supplies prescription drugs to the nursing facility. One health plan ICRC interviewed reported that it contracts with its own pharmacists to provide MTM and provide clinical teams with educational resources.
  - **CMS dementia care initiative.** Under a CMS initiative to improve dementia care in nursing homes, CMS is emphasizing non-pharmacological alternatives for nursing facility residents.<sup>28</sup> MMPs could build on these initiatives by encouraging nursing facilities to offer some of these alternatives.
- **Contracting with selected nursing facilities.** States could encourage or permit MMPs and D-SNPs to contract with a select set of nursing facilities based on compatibility between the mission, goals, and operations of the plan and the nursing facility, as long as the plan networks comply with CMS network adequacy standards.<sup>29</sup> Interviewees from two health plans reported that they contract with nursing facilities selectively based on how closely aligned the facility’s goals and operations are with the plan. One plan reported that it is important to “have the right fit” from both an operational and clinical perspective. For example, this plan has a “treat-in-place” model that encourages treatment in the nursing facility rather than in a hospital whenever it is feasible and appropriate, and it only contracts with facilities that are willing to use that model.
- **Monitoring data.** All three plans interviewed review data regularly on hospitalizations and/or readmissions, and at least two review these data with facilities as a mechanism to help educate the staff and avoid similar hospitalizations in the future. However, none of them penalize nursing facilities based on their rate of potentially avoidable hospitalizations. One interviewee noted that facility staff have to make a decision about hospitalization based on clinical symptoms observed in the nursing facility, and that the diagnoses used by CMS to identify potentially avoidable hospitalizations are not made until the individual arrives at the hospital.
- **Taking advantage of CMS initiatives that aim to reduce readmissions.** Section 3025 of the Affordable Care Act established the Hospital Readmissions Reduction Program (HRPP), which requires CMS to reduce Medicare payments to hospitals that have excess readmissions for discharges beginning on October 1, 2012.<sup>30,31</sup> The implementation of this program increases the likelihood that hospitals will be willing to work

with states, plans and nursing facilities to reduce readmissions by, for example, improving discharge planning and care coordination for nursing facility residents hospitalized for one of the conditions included in the HRPP.<sup>32</sup> Health plans ICRC spoke with reported that hospitals are increasingly willing to work with plans and nursing facilities to try to reduce avoidable hospitalizations and readmissions, such as coordination between plan staff members and hospital discharge planners and social workers, although working with different systems that do not communicate with one another remains a challenge.

Similarly, Section 215 of the Protecting Access to Medicare Act of 2014 directs the Secretary of Health and Human Services to specify a measure of hospital readmissions from SNFs by October 1, 2015 and a measure of potentially preventable hospital readmissions from SNFs by October 1, 2016.<sup>33</sup> SNFs will receive confidential quarterly performance reports beginning on October 1, 2016, and reports will be made publicly available no later than October 1, 2017. SNFs may receive value-based incentive payments beginning in fiscal year 2019 based on performance or improvement on these measures. The prospect of being publicly measured and rewarded for reducing hospital readmissions may encourage nursing facilities that provide skilled care to start taking steps now aimed at reducing readmissions, and in particular, potentially preventable readmissions. MMPs and D-SNPs, with state encouragement, could build on this initiative in their work with nursing facilities.

### **UPMC RAVEN Initiative: Lessons for Health Plans**

In September 2012, seven organizations were selected by CMS to participate in its *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*.<sup>34</sup> While these organizations are using a FFS rather than a capitated model, their experience working with nursing facilities can provide lessons for MMPs and other health plans serving Medicare-Medicaid enrollees in nursing facilities.

One of the participants, the University of Pittsburgh Medical Center (UPMC), is using a program called RAVEN (Reduce Avoidable Hospitalizations using Evidence-based Interventions for Nursing Facilities in Western Pennsylvania). The RAVEN program has five core elements: (1) facility-based NPs that assist with both acute and palliative care needs; (2) evidence-based clinical communication tools that help standardize clinical assessments and recommendations; (3) clinical process improvement through education of nursing facility staff and other quality improvement initiatives; (4) enhanced medication management; and (5) use of telehealth to facilitate after-hours clinical communication.

The UPMC staff interviewed said they believe a “whole house” approach will work best to reduce avoidable hospitalizations. To be most effective, they believe, an NP must be working with all or nearly all residents in a nursing facility rather than only a small number of residents affiliated with a particular payer. In these situations, the nursing facility, insurance company, health system, and providers each have a stake in the outcome, making it more likely that these entities will collaborate and achieve desirable results such as reducing avoidable hospitalizations. Individual MMPs and D-SNPs are not likely to be responsible for a large portion of a nursing facility’s residents in most states, so partnerships among MMPs and other health plans covering nursing facility residents may be needed to approximate such a “whole house” effect. States could encourage and facilitate these partnerships.

### **Medicaid Fee-For-Service Options**

There are reimbursement-related steps states can take in the Medicaid FFS system that may be warranted on their own merits, and that could also facilitate health plan efforts to reduce avoidable nursing facility hospitalizations, since health plans typically use Medicaid FFS reimbursement as the starting point in their reimbursement negotiations with nursing facilities.

#### **1. Modify bed-hold policies.**

Medicaid bed-hold policies pay nursing facilities to reserve the beds of residents who are hospitalized in order to provide a continuous place of residence, thus making up for part of the Medicaid revenue that facilities would lose when residents are hospitalized.<sup>35</sup> As of early 2014, 33 states and the District of Columbia had a bed-hold policy for hospitalized nursing home residents who are Medicaid beneficiaries.<sup>36</sup> States could modify their bed-hold policies in a number of ways that could reduce the incentive for avoidable hospitalizations that such policies may provide. Options include eliminating a bed-hold policy or changing one or more of three components of the policy: (1) reducing the maximum number of bed-hold days; (2) reducing the proportion of the average Medicaid daily rate that

is reimbursed under a bed-hold; and (3) increasing the occupancy standard that facilities are required to meet in order to be paid for bed-hold. Besides resulting in an immediate savings for Medicaid due to reduced payments for bed-hold days, most research suggests that eliminating bed-hold policies or making them less generous is likely to reduce hospitalizations and rehospitalizations.<sup>37-40</sup>

## 2. Use nursing facility reimbursement systems that pay higher amounts for high-need residents.

States that use a “case-mix” reimbursement system that pays Medicaid nursing facilities higher amounts per day for residents with higher needs can make it more financially feasible for facilities to treat higher-acuity residents in the facility rather than hospitalizing them.<sup>41</sup> As of early 2014, 39 states and the District of Columbia had some form of acuity-based case-mix reimbursement system for their Medicaid nursing facilities. The 11 states not using case-mix reimbursement include two states that are participating in the CMS financial alignment demonstrations: Michigan and South Carolina.<sup>42</sup>

## Conclusion

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Reducing avoidable hospitalizations for long-stay nursing facility residents is one of the primary benefits expected to emerge from the CMS capitated financial alignment demonstrations and from state contracts with D-SNPs. While all those we interviewed underscored the difficulties in reducing hospitalizations for nursing facility residents, they also reported some successes and promising practices from which states and other health plans can learn. Actions that states can undertake include:

- Measuring, reporting on, and rewarding health plan performance related to avoidable hospitalizations;
- Requiring MMPs and D-SNPs to make reducing avoidable hospitalizations a focus of their Medicaid performance improvement projects and (with CMS cooperation) their Medicare quality improvement projects;
- Working with health plans to help them use the tools available in a capitated model to work with nursing facilities, hospitals, other providers, and enrollees and their families to reduce avoidable hospitalizations; and
- Modifying Medicaid FFS reimbursement systems for nursing facilities to increase incentives to avoid unnecessary hospitalizations.

## ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the **Integrated Care Resource Center** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit [www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com).

## Endnotes

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<sup>1</sup> M. Segal, et al. “Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations.” *Medicare & Medicaid Research Review*, 2014: 4 (1), p. E1-E10. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4053188/pdf/mmrr2014-004-01-b01.pdf>.

<sup>2</sup> A “person-year” refers to the use of a service by a person for an entire year. For example, if 1,000 Medicare-Medicaid enrollees were in Medicaid nursing facilities for an entire year, this study estimates that there would be a total of 285 avoidable hospitalizations among them during the course of the year.

<sup>3</sup> M. Segal, et al. op cit.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid. For example, 8 states had 165 to 197 potentially avoidable hospitalizations per 1,000 person-years in 2009, while 11 states had 59 to 96 potentially avoidable hospitalizations per 1,000 person-years.

<sup>6</sup> D. Grabowski. “Medicare and Medicaid: Conflicting Incentives for Long-Term Care.” *Milbank Quarterly*, 2007: 85(4) pp. 579-610.

<sup>7</sup> M. Segal, et al. op cit.

<sup>8</sup> Author’s analysis of Kaiser Family Foundation. State Health Facts, Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2011; MedPAC and MACPAC, Data Book, Beneficiaries Dually Eligible for Medicare and Medicaid, Table 5 and Exhibits 15 and 16, January 2015.

<sup>9</sup> The Medicare-Medicaid Coordination Office (MMCO), in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), is conducting an Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents that primarily targets fee-for-service, long-stay Medicare-Medicaid

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enrollees. More information about this initiative is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html>

<sup>10</sup> Medicare nursing home resident hospitalization rates were the subject of a November 2013 report by the Department of Health and Human Services Office of Inspector General, which recommended that CMS develop a quality measure to describe hospitalization rates and instruct state survey agencies to review the quality measure as part of the certification process. More information is available at <http://oig.hhs.gov/oei/reports/oei-06-11-00040.pdf>.

<sup>11</sup> For more details on these D-SNP contracting arrangements in 12 states, see J. Verdier, A. Kruse, R.S. Lester, A.M. Philip, and D. Chelmsky. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs): Issues and Options." Integrated Care Resource Center, February 2015. Available at: <http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf>.

<sup>12</sup> S. Zainulbhai, et al. "Assessing Care Integration for Dual Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative." Issue Brief. The Commonwealth Fund, March 2014. Available at: [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/Mar/1724\\_Zainulbhai\\_care\\_integration\\_dual\\_eligibles\\_ib.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/Mar/1724_Zainulbhai_care_integration_dual_eligibles_ib.pdf). Accessed June 25, 2014.

<sup>13</sup> Examples are from Zainulbhai, et al.

<sup>14</sup> Federal Medicaid regulations related to EQROs and performance improvement projects are at 42 CFR §438.240 and §438.358.

<sup>15</sup> 42 CFR §422.152 and §422.153.

<sup>16</sup> MedPAC, "Report to Congress: Aligning Incentives in Medicare." June 2010. Available at [http://www.medpac.gov/documents/jun10\\_entirereport.pdf](http://www.medpac.gov/documents/jun10_entirereport.pdf).

<sup>17</sup> Milliman Care Guidelines. "Recovery Facility Care." Available at <http://www.mcg.com/sites/default/files/recoveryfacilitycare.pdf>.

<sup>18</sup> L. Lipsitz. "The 3-Night Hospital Stay and Medicare Coverage for Skilled Nursing Care." *Journal of the American Medical Association*, 2013; 310(14) pp.1441-1442.

<sup>19</sup> J. Verdier, et al. op cit. p. 17.

<sup>20</sup> 42 CFR §409.30(b)(2); CMS, "Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2016 Call Letter." February 20, 2015, pp. 137-138.

<sup>21</sup> M. Perry, et al. "To hospitalize or not to hospitalize? Medical care for long-term care facility residents." Washington, DC: Kaiser Family Foundation, October 2010. Available at: <http://kff.org/health-costs/report/to-hospitalize-or-not-to-hospitalize-medical/>.

<sup>22</sup> R. L. Kane, et al. "The Effect of Evercare on Hospital Use." *Journal of the American Geriatrics Society*, 2003; 51 pp.1427-1434.

<sup>23</sup> W. D. Spector. "Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes." *Medical Care*, 2013; 51(8) p. 673.

<sup>24</sup> The Medicare Modernization Act of 2003, as amended by the ACA in 2010, requires that Medicare Part D plans have a medication therapy management (MTM) program. MTM aims to optimize outcomes and reduce the risk of adverse events by improving medication use. MTM programs are required to establish the following: automatic enrollment with an opportunity to opt out; an annual comprehensive medication review (CMR); and quarterly targeted medication reviews of at-risk enrollees with follow-up interventions when necessary.

<sup>25</sup> MTM programs target beneficiaries with multiple chronic diseases, taking multiple Part D drugs, and high annual Part D drug costs. For more information, see J. M. Verdier. "Medicare Part D Prescription Drug Coverage for Medicare-Medicaid Enrollees in the Capitated Financial Alignment Demonstration." Integrated Care Resource Center, March 2013. Available at: [http://www.integratedcareresourcecenter.net/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20\(2-22-13\).pdf](http://www.integratedcareresourcecenter.net/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20(2-22-13).pdf).

<sup>26</sup> Since 2013, Part D plans have been required to offer CMRs to nursing facility residents, and CMS recommends that Part D plans coordinate with the nursing facility's consultant pharmacist. For more information, see C. Tudor. "CY 2013 Medication Therapy Management Program Guidance and Submission Instructions." April 10, 2012. Available at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Memo-Contract-Year-2013-Medication-Therapy-Management-MTM-Program-Submission-v041012.pdf>.

<sup>27</sup> For details, see J.M. Verdier. "Medicare Part D Prescription Drug Coverage for Medicare-Medicaid Enrollees in the Capitated Financial Alignment Demonstration." Integrated Care Resource Center, March 2013. Available at: [http://www.integratedcareresourcecenter.net/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20\(2-22-13\).pdf](http://www.integratedcareresourcecenter.net/pdfs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20(2-22-13).pdf).

<sup>28</sup> Centers for Medicare & Medicaid Services. "Interim Report on the CMS National Partnership to Improve Dementia Care in Nursing Homes." April 11, 2014. Available at: <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-19.pdf>.

<sup>29</sup> Medicare Advantage plans must comply with CMS network adequacy requirements in contracting with SNF and other providers. The requirements are county-specific and are based on provider numbers and travel time and distance for beneficiaries. For details, see CMS, "CY 2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance." Available at: [http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016\\_MA\\_HSD\\_Network\\_Criteria\\_Guidance.pdf](http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016_MA_HSD_Network_Criteria_Guidance.pdf).

<sup>30</sup> Centers for Medicare & Medicaid Services. "Readmissions Reduction Program." Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>.

<sup>31</sup> J. James. "Medicare Hospital Readmissions Reduction Program." *Health Affairs*, Health Policy Brief, November 12, 2013. Available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_102.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf).

<sup>32</sup> The first three conditions included in the HRPP were acute myocardial infarction, heart failure, and pneumonia. Beginning in fiscal year 2015, the HRPP also includes elective hip or knee replacement and congestive obstructive pulmonary disease.

<sup>33</sup> Protecting Access to Medicare Act of 2014, Public Law 113-93, April 1, 2014.

<sup>34</sup> For more information about this initiative, see <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html>

<sup>35</sup> O. Intrator et al. "Hospitalization of Nursing Home Residents: The Effects of States' Medicaid Payment and Bed-Hold Policies." *Health Services Research*, 2007; 42 pp. 1651.

<sup>36</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), "State Medicaid Payment Policies for Nursing Facility Services." October 2014. Available at: <https://www.macpac.gov/publication/nursing-facility-payment-policies/>.

<sup>37</sup> O. Intrator et al. op cit.

<sup>38</sup> D. Grabowski et al. "Medicaid bed-hold Policy and Medicare Skilled Nursing Facility Rehospitalizations." *Health Services Research*, 2010; 45(6) p. 1980.

<sup>39</sup> S. Cai et al. "Hospitalizations in Nursing Homes: Does Payer Source Matter? Evidence from New York State." *Medical Care Research and Review*, 2011; 68 p. 559.

<sup>40</sup> M. Unruh et al. "Medicaid Bed-Hold Policies and Hospitalization of Long-Stay Nursing Home Residents." *Health Services Research*, 2013; 48(5) p. 1617.

<sup>41</sup> Z. Feng, et al. "The Effect of State Medicaid Case-Mix Payment on Nursing Home Resident Acuity." *Health Services Research*, 2006; 41(4) Part 1.

<sup>42</sup> MACPAC op. cit.