During the past several years, the nation’s health systems and providers have frantically put into place programs to reduce readmission rates for heart failure (HF) and other conditions. Through public reporting or pay for performance initiatives focused on readmissions, hospital administrators now focus on care beyond the hospital doors. The basis for improving readmission rates largely rests on Medicare data showing wide variation and attributable costs of early readmissions among elderly Americans. Given that this population is the highest payer of the nation’s $1.6 trillion in hospital bills,1 the rationale to focus on Medicare beneficiaries is understandable. Certainly, Medicare must focus on resource-intensive conditions with poor outcomes like HF. Historically, other payers like Medicaid have had other areas in which to focus quality improvement efforts. With a predominantly younger population, maternal and neonatal stays account for 50% of all hospitalizations;2 however, the state of affairs may soon change for Medicaid plans. In 2014, states may opt to expand Medicaid as part of the Affordable Care Act—a landmark legislation that promises to expand coverage across the spectrum of health and disease. As a result, it is important to understand the impact of a condition like HF, which has high morbidity and mortality, on Medicaid programs. Furthermore, we must begin to define what may drive inefficiencies or poor quality of care for this population.

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In this issue of Circulation: Heart Failure, Allen et al help us to understand the other 20% to 30% of HF that is unrepresented by previous studies profiling Medicare beneficiaries.3 Using administrative data from MarketScan, the authors describe rates and predictors of 30-day readmission among Medicaid and commercially insured patients hospitalized with systolic HF. A striking finding was the observed 30-day readmission rates were lower for Medicaid (17.4%) recipients and commercially insured patients (11.8%) compared with the previously reported Medicare rate of 24.7%.4 The high rate of other causes for readmission is consistent with observations in the Medicare HF population. The non-HF diagnoses represent the majority of primary reasons for readmission. In contrast, Medicaid enrollees had a 6.7% rate of 30-day readmissions for HF, and commercially insured patients had only a 4.0% rate. After adjusting for severity of illness based on administrative claims, Medicaid patients were 1.32 times more likely (95% confidence interval: 1.09–1.60) than commercially insured patients to be readmitted for any cause and 1.68 times more likely (95% confidence interval: 1.26–2.24) to be readmitted for HF.

Before using these findings to estimate readmission risk of HF in the non-Medicare population, it is important to note the limitations of using a narrowly defined study population and administrative data. In an attempt to obtain a more homogeneous population, the authors limited their analysis only to HF with reduced ejection fraction (HF-REF) using International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. Lacking a clinical assessment of ejection fraction, the study population is likely mischaracterized as a homogeneous population with HF-REF. Regardless, the exclusion of HF patients with preserved ejection fraction limits the generalizability of these findings for the broader Medicaid population. In an observational analysis of more than 110,000 patients hospitalized with HF (of which, approximately half did not have Medicare), HF patients with preserved ejection fraction accounted for more than one-third of all hospitalizations and increased in incidence relative to patients with HF-REF.5 Moreover, the basis for focusing on the HF-REF population does not represent the current focus of our nation’s readmission problem. Although the evidence on how to improve HF-REF long-term outcomes is strong, there is limited data to show that any readmission issue or transitional care problem is different for HF patients with preserved ejection fraction compared with HF-REF patients. Despite the heterogeneity of the broader HF population, including all patients would provide a more direct comparison to publicly reported readmission rates for Medicare beneficiaries, which are now used to financially penalize hospitals with excessive rates.6 These penalties are more likely to affect hospitals that disproportionately care for poor patients and, therefore, have limited resources to invest in quality improvement initiatives that might reduce preventable readmissions.7 For these hospitals, it is particularly important to understand the full scope of the problem in caring for Medicaid patients with HF.

The authors also exclude low-income elderly and disabled patients who are dually eligible for Medicaid and Medicare. These dual eligibles are likely one of the most challenging groups to care for. This subgroup includes nearly all of Medicaid’s elderly patients who use the program to offset the costs of not only services like long-term care but also Medicare premiums, deductibles, and coinsurance. In 2000, dual eligibles represented 16% of all Medicaid enrollees and 42% of program

Addressing the 100% of Heart Failure: A Call for Complete Care of All Ages

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spending. In 2008, nearly 8 million Medicare beneficiaries were also enrolled in their states’ Medicaid programs. In dual eligibles, HF is the leading cause of hospitalization among chronic conditions. Therefore, these high-risk patients should be included in the analysis in order to understand the short-term outcomes of HF in the overall Medicaid population, which is presumably worse than what is estimated in this study.

Nevertheless, this study identifies an association of Medicaid status with poor outcomes in HF, which is concordant with prior work. In Get With The Guidelines–Heart Failure, a nationwide clinical registry, higher adjusted rates of in-hospital mortality were seen in Medicaid recipients. In New York, Medicaid status has been associated with higher readmission rates compared with health maintenance organizations and an independent predictor of higher readmission risk. In Maryland and Massachusetts, Medicaid patients were 1.8 times more likely to be hospitalized for HF. In the Atherosclerosis Risk in Communities cohort, which spans communities in 4 states, Medicaid enrollees without a high burden of comorbidity still had an increased hazard of all-cause rehospitalization and a higher rate of repeat hospitalizations compared with non-Medicaid enrollees.

The authors provide a useful comparison of Medicaid recipients with commercially insured patients, but a comparison of Medicaid recipients with the uninsured is even more relevant. Beginning in 2014, the Affordable Care Act provides for significant expansion of Medicaid eligibility. Of the 48.6 million uninsured Americans, approximately half would be eligible to enroll in Medicaid under the new legislation; however, the United States Supreme Court ruling limits federal authority to enforce expansion through withholding existing federal program funds. States now face a decision of whether to expand Medicaid or leave millions without coverage. Individuals above the federal poverty level would qualify for subsidies that would help them obtain commercial insurance through new health insurance exchanges, but individuals below the poverty level would not. In 2010, there were 16 million uninsured adults below the poverty level.

For states deciding whether to expand Medicaid, it is critical to understand the immediate financial costs and the long-term consequences for population health. This policy decision, which will largely determine whether healthcare reform improves access to care, may impact the morbidity that patients face and the costs associated with poorer clinical outcomes. For a nation whose fiscal solvency is threatened by rising healthcare costs, it is critical to understand the problem chronic conditions like HF present not solely for Medicare beneficiaries, but for the entire American population. In addition to defining the problem fully, we must continue to test solutions, compare valid ones, and implement the best. This will require a coordinated effort among clinicians, researchers, and decision makers to improve the value of health care by developing evidence-based policy in the best interests of our patients and citizens.

Disclosures
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