Below please find the Fall 2009 edition of *News from ORDI*, a quarterly publication summarizing recent work undertaken in ORDI and the results we've produced. Highlights from this quarter's *News* include:

- Publication of the Fall 2009 edition of the *Health Care Financing Review*, CMS' journal of information, analysis, and research on a broad range of issues affecting the Medicare and Medicaid programs.
- New research reports and published articles by CMS staff.
- New program demonstrations and research projects.

I hope you find this information useful. For additional ORDI-related information, please visit our website.

Timothy P. Love

Director, Office of Research, Development, and Information

1. *Health Care Financing Review*

ORDI has released the Fall 2009 edition of the *Health Care Financing Review*, the agency's journal of information, analysis, and research on a broad range of health care financing and delivery issues. This issue includes articles on, among other topics, understanding electronic health record (ERH) use in small physician practices, colon cancer treatment costs for Medicare beneficiaries, and Medicaid expansions and insurance coverage of poor teenagers.

Click here to view the Fall edition, as well as previous issues.

To request copies of the printed edition, please contact Patty Manger at 410-786-3253 or patty.manger@cms.hhs.gov.

2. 2009 *CMS Statistics*

The 2009 edition of *CMS Statistics* is now available. *CMS Statistics* is an annual publication prepared as a handy reference document for CMS leadership and staff. (*CMS Statistics* is also available to the general public and is uploaded to the CMS website.)

The data are comprehensive, with summary CMS program information that can serve as background for briefings, position papers, or a source for answering questions from Congressional staff and the public.

The electronic version of the 2009 *CMS Statistics* is available here. For copies of the publication, please contact Gerald Wright at 410-786-5798 or gerald.wright@cms.hhs.gov. For data questions, please contact Maria Diacogiannis at 410-786-0178 or maria.diacogiannis@cms.hhs.gov.

3. 2009 *Wallet Card*

The *Wallet Card* provides our most frequently requested data, presented in a concise, easy-to-read format. This publication is a quick reference on program and financial statistics.

The electronic version of the 2009 *Wallet Card* is now available here. For copies of the card, please contact Gerald Wright at 410-786-5798 or gerald.wright@cms.hhs.gov. For data questions, please contact Maria Diacogiannis at 410-786-0178 or maria.diacogiannis@cms.hhs.gov.

4. *The 2008 CMS Statistical Supplement is Featured on Data.gov*

The complete group of data tables from the *2008 Statistical Supplement* publication is one of the featured tools that are highlighted on the new Data.gov website. Data.gov increases the ability of the public to easily find, download, and use datasets that are generated and held by the Federal Government. As it states on the Data.gov website: "The purpose of Data.gov is to increase public access to high value, machine readable datasets generated by the Executive Branch of the Federal Government. Data.gov includes searchable data catalogs providing access to data in three ways: through the 'raw' data catalog, the tool catalog and the geodata catalog."

Click here to go to Data.gov.

5. Published Articles

Physician Evaluation and Management of Medicare Home Health Patients
Authors: Jennifer L. Wolff, Ph.D., Ann Meadow, Sc.D., Cynthia M. Boyd, MD., M.P.H, Carlos O. Weiss, MD., M.H.S., and Bruce Leff, MD.
Publication: *Medical Care* 47(11):1147-1155, November 2009.

The Medicare home health benefit is predicated on physician referral and involvement. In this study, the authors investigated (1) the frequency and (2) implications of home health patients' evaluation and management by community physicians. Data came from the CMS Chronic Condition Warehouse (CCW) and were analyzed while Dr. Wolff participated in an Intergovernmental Personnel Agreement with CMS.

More than one-third (34.6%) of patients did not receive physician evaluation and management visits during their home health episode. Home health patients most commonly incurred physician office visits exclusively (51.5%) or in combination with consultations (6.8%) or house call visits (2.2%), as well as house call visits exclusively (3.3%). Patients who incurred physician evaluation and management visits during their episode of care were more likely to be discharged from home health agencies than their counterparts who did not (77.9% vs. 70.6%, respectively). The association between physician visits and home health discharge was statistically significant in both simple regression models (odds ratio = 1.47; 95% confidence interval [CI], 1.42–1.52) and in multivariate analyses accounting for socio-demographic factors, health, and functioning (odds ratio = 1.45; 95% CI, 1.40 –1.51).

More systematic integration of physicians in home care processes may reduce subsequent hospital and other inpatient facility use among home health patients.

For more information, please contact Ann Meadow at 410-786-6602 or ann.meadow@cms.hhs.gov.

Adverse Selection in the Medicare Prescription Drug Program

Authors: Gerald F. Riley M.S.P.H.; Jesse M. Levy Ph.D.; Melissa A. Montgomery Ph.D.

Publication: *Health Affairs* 28(6): 1826-1837, November/December 2009.

The Medicare Part D drug benefit created choices for beneficiaries among many prescription drug plans with varying levels of coverage. As a result, Medicare enrollees with high prescription drug costs have strong incentives to enroll in Part D, especially in plans with more comprehensive coverage. To measure this potential problem of "adverse selection", which could threaten plans' finances, we compared baseline characteristics among groups of beneficiaries with various drug coverage arrangements in 2006. We found some significant differences. For example, enrollees in stand-alone, prescription drug plans, especially in plans offering benefits in the coverage gap, or "doughnut hole", had higher baseline drug costs and worse health than enrollees in Medicare Advantage prescription drug plans. Although risk-adjusted payments and other measures have been put in place to account for selection, these patterns could adversely affect future Medicare costs and should be watched carefully.

For more information, please contact Gerald Riley at 410-786-6699 or Gerald.Riley@cms.hhs.gov.

National Study of Medications Associated with Injury in Elderly Medicare/Medicaid Dual Enrollees During 2003
Authors: Steven Blackwell, Melissa Montgomery, Dan Waldo, David Baugh, Gary Ciborowski, and David Gibson
Publication: *Journal of American Pharmacists Association* 49(6):751-759, 2009.

We assessed Beers medications and non-Beers medications with potential central nervous system side effects of dizziness/vertigo, drowsiness, and/or fainting. Emergency room visits with admitting diagnoses pertaining to injuries for elderly enrollees dually eligible for Medicare and Medicaid during the calendar year 2003 were linked to prescriptions filled during the 90 days preceding the visit. For each drug in our study, we calculated the proportion of emergency room-related fills and the Medicare average revenue charge per injury-related emergency room visit.

Several drugs not currently on the Beers list were found to be associated with high proportions of ED-related fills: methadone had the highest proportion of any of the drugs studied (12.3 per 1,000 fills), and bethanechol (7.8 per 1,000 fills) had the highest proportion among genitourinary products. Regarding narcotic analgesics, propoxyphene (7.7 per 1,000 fills) had a higher association with injury than morphine (6.6 per 1,000 fills) or tramadol (6.5 per 1,000 fills). For cardiovascular agents, clonidine (4.7 per 1,000 fills) and doxazosin (3.6 per 1,000 fills) had higher associations with injury than nifedipine (3.3 per 1,000 fills). Fentanyl, a non-Beers medication, was associated with the most expensive injury-related ED visits ($1,263 average revenue charge).

Beers medications are associated with high injury-related ED visit rates for the elderly, and a number of drugs not currently on the Beers list also pose an apparent risk for injury-related visits.

For more information, please contact Steve Blackwell at 410-786-6852 or Steve.Blackwell@cms.hhs.gov.

6. New Research Reports

Geographic Variation in Drug Prices and Spending in the Part D Program

In 2003, the Medicare Prescription Drug Improvement and Modernization Act (MMA) mandated the creation of a voluntary program for prescription drugs within Medicare, administered by the Centers for Medicare & Medicaid Services (CMS). Described as the "most important health care legislation passed by Congress since the enactment of Medicare and Medicaid in 1965," the drug benefit filled a critical gap in Medicare

coverage. This report investigates regional variation in per capita expenditure on covered Part D drugs and Part D drug prices as reported in prescription drug event (PDE) data submitted by prescription drug plans.

The electronic version of the report is available here. For additional information, please contact Jesse Levy at 410-786-6600 or jesse.levy@cms.hhs.gov.

Medicare Part B Drug and Biologicals Competitive Acquisition Program: Survey Analysis Comparing Satisfaction of Participating and Nonparticipating Physicians

Section 303(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Pub. L. 108-173) introduced a Competitive Acquisition Program (CAP) for selected outpatient drugs and biologicals covered under Medicare Part B. Under this program, Medicare chooses drug supply vendors through a competitive bidding process. Physicians may elect to participate in the program annually, in which case they purchase selected Part B drugs through a CAP vendor. In late 2005, the Centers for Medicare & Medicaid Services (CMS) conducted the first round of bidding for approved CAP vendors. Physicians were first able to acquire drugs through the CAP on July 1, 2006. This report includes results of a survey of participating physicians. The CAP-electing physician survey included 25 questions on practices' reasons for electing to participate in the CAP; their overall satisfaction with the program and the CAP vendor BioScrip; their satisfaction with acquiring drugs under the CAP, including through the use of the Furnish as Written (FAW) and Emergency Restocking processes; specific problems encountered by physicians and their patients under the CAP system; and physician characteristics and typical drugs administered.

The electronic version of the report is available here. For additional information, please contact Jesse Levy at 410-786-6600 or jesse.levy@cms.hhs.gov.

The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Medicare and Medicaid Expenditures

The Balanced Budget Act of 1997, required an evaluation of the permanent PACE program. PACE organizations are required to accept monthly capitation payments from Medicare, Medicaid, and private sources. This type of financing is intended to allow providers the flexibility to deliver all health care-related needs of participants. A relevant policy question is how the capitation payment compares with what would have been paid in the absence of PACE, i.e., if the beneficiaries remained in the traditional fee-for-service (FFS) system. A comparison of capitated payments was made to PACE organizations with expenditures projected as if their enrollees remained in traditional Medicare and Medicaid programs under a FFS arrangement. For Medicare, a comparison was made for the first 60 months after enrollment into PACE in 1999 or 2000; for Medicaid, the comparison could only be made for the first 24 months after entry because of data limitations. Little difference was found between the Medicare capitated payments

to PACE and predicted Medicare expenditures that would have been incurred in the absence of PACE for the beneficiaries who entered PACE in 1999 or 2000 in nine study states. This suggests that the capitation payments for Medicare were set appropriately (at the projected FFS levels) over the 60 month review period. The analysis also suggest that PACE was associated with higher Medicaid payments than would have been experienced in the absence of PACE over the 24 month review period. However, the abbreviated study period likely did not include long-term care nursing home and other institutionalization costs, costs that would be normally incurred by Medicaid later in a person's care trajectory. The difference between the Medicaid capitated rates and projected expenditures was $926 per person per month in first 6 months, versus $536 per person per month in the last six months of the review. This decline suggests that higher expenses, possibly long term nursing home care, were entering the analysis as participant's age. Thus, the adequacy of the Medicaid capitation rates cannot be measured reliably for periods that extend beyond the 24 month period.

The electronic version of the report is available here. For more information, please contact Fred Thomas at 410-786-6675 or fred.thomas@cms.hhs.gov.

7. Current Demonstrations and Research Projects

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

President Obama directed the Department of Health and Human Services (HHS) to implement a demonstration to support federally qualified health centers (FQHCs) in delivering advanced primary care to Medicare beneficiaries. This demonstration will evaluate whether FQHCs that deliver advanced primary care improve access and quality, promote appropriate use of services, and reduce health care costs. The Centers for Medicare & Medicaid Services (CMS) and Health Resources and Services Administration will collaborate on the development of the demonstration, which will be administered by CMS. A solicitation for applications from FQHCs is planned for spring 2010, with the demonstration expected to begin in January 2011. CMS anticipates that 500 FQHCs will participate in the 3-year demonstration.

Additional information about the demonstration is available here. You may also contact Jim Coan at 410-786-9168 or James.Coan@cms.hhs.gov.
