Below please find the Spring 2010 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:

- Release of the 2010 *Active Projects Report (APR)*.
- The announcement of the new *Medicare & Medicaid Research Review (MMRR).*
- New research-related data files located on the CMS website.
- New research reports 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**.

Tom Reilly

Acting Director, Office of Research, Development, and Information

1. *Active Projects Report (APR)*

The 2010 edition of the *Active Projects Report* is now available on our web site. The *Active Projects Report* is a comprehensive guide to CMS' demonstration, evaluation, and research activities, providing a brief description of each project and its status. The APR also provides the name of the CMS project officer, the awardee, funding, the period of performance, and other useful information. It is available online here.

For more information, please contact Jim Beyer at 410-786-6693 or James.Beyer@cms.hhs.gov.

2. *The Medicare & Medicaid Research Review (MMRR)*

While the Health Care Financing Review (HCFR) has served its readership and the Centers for Medicare & Medicaid Services (CMS) well for a number of years, recent changes in CMS programs, along with the current range of publication technology options, had convinced us to redirect both our editorial focus and dissemination medium.

CMS is pleased to announce our new journal, the Medicare & Medicaid Research Review (MMRR). The goal of this new, digital, peer-reviewed publication will be to serve as the definitive source for reports of well designed, methodologically rigorous, and policy relevant research on the Medicare, Medicaid, and Children's Health Insurance programs. The launch and development of MMRR is a priority initiative for The Office of Research, Development, and Information (ORDI). ORDI's goal is to ensure that not only our new journal is a worthy successor to the Health Care Financing Review, but the publication is commensurate to the CMS mission in an era of major health care reform.

Until our new journal becomes available on-line later this year, please monitor the HCFR website for updates. You may also submit new manuscripts for consideration to MMRR-Editors@cms.hhs.gov.

For more information, please contact David Bott, the Editor-In-Chief, at 410-786-0249 or David.Bott@cms.hhs.gov.

3. CMS Comparative Effectiveness Research Public Use Data and Access Solution Pilot

Comparative Effectiveness Research (CER) is designed to compare different interventions to prevent, diagnose, treat, and monitor health conditions. These interventions may include medications, procedures, medical and assistive devices and technologies, behavioral change strategies, delivery system interventions, and the like. This information can be used to develop practice guidelines and other methods to promote informed health care decision-making. Armed with this information, health care providers and beneficiaries can select treatments that are most likely to lead to improved health and functioning. As providers and patients are able to focus on treatments that are more effective, we also expect to see program savings over time.

As a by-product of administering the Medicare program, CMS maintains one of the most comprehensive administrative data resources anywhere to support such applications. We have claims data for all fee-for-service Medicare beneficiaries (about 80% of the Medicare population) for different settings and types of care including inpatient and outpatient hospitals, skilled nursing facilities, home health, hospice, physicians/suppliers, durable medical equipment, and prescription drugs. To date, researchers need to pay CMS a recovery-of-cost fee to generate files from the data repository. For many researchers, this fee represents a significant barrier to being able to obtain the data needed to conduct CER.

The purpose of this project is to increase access to CMS claims data through the creation of de-identified data sets and a public access solution. Phase one of the project will focus on CY2008 CMS claims data. These initial data sets will contain a basic set of data elements determined to be useful to researchers and data entrepreneurs, while continuing to strictly protect beneficiary confidentiality. These files and supporting user documentation will be available for download in the near future on the CMS website.

For more information, please contact Chris Haffer at 410-786-8764 or Chris.Haffer@cms.hhs.gov.

4. Medicare Current Beneficiary Survey (MCBS): 2008 Access to Care Available

In May 2010, the 2008 Access to Care data file became available for use. The MCBS is a continuous survey utilizing a nationally representative sample of the Medicare population. The sample for this file represents the "always enrolled" population, who are those individuals who participated in the Medicare program for the entire year. The Access to Care file is released annually and marks the seventeenth year of collection. The file contains information on beneficiaries' access to and satisfaction with health care, usual source of care, health status and functioning, health insurance, household composition, and beneficiary knowledge of the Medicare program. Of special interest this year is the inclusion of questions related to diabetes and osteoporosis. These questions are rotated into the questionnaire every two years and were last collected in 2006.

For more information or to receive access to the data file, please contact Joanne Francy (410) 786-4881 or Joanne.Francy@cms.hhs.gov.

5. New Research Reports

Alternative Approaches to Measuring Physician Resource Use: Interim Report

The goal of this project was to explore potential measures that would support public reporting and a payment system that would reward physicians in traditional fee-for-service (FFS) Medicare for efficient and high "quality" care. This report provides initial perspectives on measuring physician resource use in Medicare.

The electronic version of the report is available here.

For more information, please contact Craig Caplan at 410-786-4165 or Craig.Caplan@cms.hhs.gov.

Challenges in the Risk Adjustment of Episode Costs

This study investigated the challenges and issues encountered in risk adjusting the costs of episodes built by Ingenix's Symmetry Episode Treatment Groups (ETG) and Thomson Reuters' Medstat Medical Episode Grouper (MEG). The analysis explores use of several

regression approaches to risk adjust episode costs controlling for beneficiary demographics, specialties of attributed physicians, and beneficiary health conditions. The data consists of episodes created by the ETG and MEG groupers using 2002-2004 Medicare claims for all beneficiaries residing in Oregon who were continuously enrolled in the fee-for-service (FFS) Part A and B programs while alive.

The study finds that risk adjustment reduces the dispersion in episode costs, although it also increases the magnitude of high-cost outliers. All risk adjustment regression specifications lead to large reductions in dispersion of costs for the highest-expense episode types as measured by the 90th/10th percentile ratio. Not surprisingly, use of episode-level health risk scores produces the greatest reductions, shrinking the average 90/10 percentile ratio by 34% for ETG and by 48% for MEG. However, using episode-level risk scores sharply increases the severity of high-cost outliers for several episode types. Risk adjustment specifications incorporating episode-level health risk factors increase the fraction of cost captured in the top five percentiles by an average of 24% for ETG and 17% for MEG. Other specifications have little impact on the percent of costs in the top five percentiles. The sharp increase in the severity of high-cost outliers induced by risk adjustment is particularly striking in the case of hip fracture episodes, where risk adjustment increases the fraction of costs captured by the top five percentiles of the cost distribution by over 200%.

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.

Developing Outpatient Therapy Payment Alternatives (DOTPA): 2007 Utilization Report

The annual report summarizes progress on stakeholder involvement, instrument design, data collection, and analyses conducted to date. Progress outlined in the 2010 report includes the following:

1) Discussion on the development and submission of the Paperwork Reduction Act package; and
2) Discussion on the anticipated activities, including the start of data collection, in year three of this five-year project.

The annual utilization report provides high-level estimates of the utilization of and expenditures for outpatient therapy services using CMS claims from the most recently available calendar year. These analyses update previous utilization analyses conducted for CMS between 1998 and 2009.

The electronic version of the report is available here.

For more information, please contact David Bott at 410-786-0249 or David.Bott@cms.hhs.gov

Electronic Health Records Demonstration: Office Systems Survey

The Office Systems Survey is being used in the Electronic Health Records (EHR) Demonstration to measure the extent of a physician practice's use of EHRs and related functionalities. Practices' scores will be used to determine the incentive payment for use of the minimum core EHR functions and the extent of EHR use. Scores will also be used in the evaluation to assess practices' progress in use of EHRs over the course of the demonstration.

An electronic version of the survey instrument is available here.

For more information, please contact Lorraine Johnson at 410-786-9457 or Lorraine.Johnson@cms.hhs.gov

Evaluating the Stability of Physician Efficiency Scores

The goal of reducing Medicare costs has prompted some policymakers to propose pay-for-performance schemes targeted at increasing the efficiency of Medicare providers. One method for assessing physician efficiency uses episode grouping software as a basis for comparing a provider's level of resource utilization to that of his peers. Such software constructs episodes of care from information on medical claims. Given rules for calculating the costs of episodes and for attributing episodes to the providers responsible for them, one can use episode costs to formulate physician resource utilization scores. Before Medicare could use these scores to evaluate physician performance, however, researchers must demonstrate that these proposed scoring methods are reliable.

Evaluating the stability of these scores over time provides a test concerning whether the physician resource utilization measures are in fact reliable. Assuming actual provider practice patterns change little from year to year, observing stable physician efficiency scores provides evidence of a reliable scoring method. This report investigates score stability using Oregon Medicare episodes from 2003 and 2005. To construct these episodes from claims data, this analysis relies on two prominent commercial groupers: Ingenix's Symmetry Episode Treatment Groups (ETG) and Thomson Reuters' Medstat Medical Episode Grouper (MEG). This report examines the stability of two formulations of efficiency scores: (i) overall (or composite) scores that combine a provider's episode-specific scores into a single measure, and (ii) episode-specific scores that measure a provider's relative resource use for care associated with particular types of health conditions.

Broadly, this report shows that physician scores based on ETG and MEG grouped episodes display decidedly mixed levels of stability. In particular, the analysis finds that:

- Composite physician resource utilization scores exhibit only modest levels of stability over time. The one-year correlation of physician scores ranges from 0.46 to 0.60. Additionally, physicians classified as the highest-cost providers in a given year have less than a 50% likelihood of being classified as such in a following year.
- Physicians' episode-specific scores exhibit even less stability. The one-year correlation of physician scores is generally less than 0.45. However, as this calculation requires that a physician have at least 10 episodes per type to be scored, around 90% of episode-specific scores are dropped from the analysis. When no episode minimum is imposed, more physicians receive scores but stability falls even further, with the correlation between scores from one year to the next at around 0.15.

The electronic version of the report is available here.

For more information, please contact Fred Thomas, Ph.D. at 410-786-6675 or Fred.Thomas@cms.hhs.gov.

Evaluation of the Competitive Acquisition Program for Part B Drugs

Section 303(d)(2) 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. Physician practices may elect to participate in the program annually, in which case they obtain 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 examines the effects of the CAP on the range of vendor choices available to physicians, drug prices realized under CAP versus usual Part B drug payments, programmatic savings, reductions in cost-sharing, beneficiary satisfaction, access to competitively biddable drugs and biological, and satisfaction among participating physicians. This report updates analyses presented in a previous Report to Congress (DHHS, 2009). Differences in updated data sources, analytic methods, and findings between the Report to Congress (RTC) and this report are noted.

The electronic version of the report is available here.

For more information, please contact Jesse Levy at 410-786-6600 or Jesse.Levy@cms.hhs.gov

Evaluation of the Extended Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration

This report provides documentation of project activities conducted during the first year of the project evaluating the extension of the Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration. The evaluation contractor, RTI International, developed comparison populations for the two non-randomized CMHCB sites and conducted evaluation site visits at the end of the project year to assess first year progress and changes. Site visit reports will be available in year two of the evaluation.

The electronic version of the report is available here.

For more information, please contact David Bott at 410-786-0249 or David.Bott@cms.hhs.gov.

Evaluation of the Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration: Care Level Management (CLM)

The purpose of this report is to present the findings from RTI International's evaluation of Care Level Management's (CLM's) Medicare Care Management for High Cost Beneficiaries (CMHCB) demonstration program. The principal objective of this demonstration is to test a pay-for-performance contracting model and new intervention strategies for Medicare fee-for-service (FFS) beneficiaries, who are high cost and/or who have complex chronic conditions, with the goals of reducing future costs, improving quality of care and quality of life, and improving beneficiary and provider satisfaction. The desired outcomes include a reduction in unnecessary emergency room visits and hospitalizations, improvement in evidence-based care, and avoidance of acute exacerbations and complications. In addition, this demonstration provides the opportunity to evaluate the success of the "fee at risk" contracting model, a relatively new pay-for-performance model, for CMS. This model provides CLM with flexibility in its operations and strong incentives to keep evolving toward the outreach and intervention strategies that are the most effective in improving population-based outcomes.

Based on extensive qualitative and quantitative analysis of performance, we find that CLM had limited success in improving key processes of care, beneficiary experience with care, self-management, or functional status, and reducing hospital admissions. CLM was most successful at reducing 90-day all-cause readmissions by -225 per 1,000 among its original beneficiaries. However, the overall set of modest improvements were achieved at substantial cost to the Medicare program in the form of monthly management fees ($58 million) with no demonstrable savings in program outlays on health services. Despite the limited gains, the lack of program savings to offset monthly management fees cannot justify the CLM model for chronically ill Medicare fee-for-service beneficiaries on cost effectiveness grounds.

The electronic version of the report is available here.

For more information, please contact David Bott at 410-786-0249 or David.Bott@cms.hhs.gov.

Evaluation of the Medicare Demonstration to Limit Annual Changes in Part D Premiums

CMS established a demonstration to phase in over three years the enrollment weighting methods for calculating the Part D national average bid stipulated in the Medicare Modernization Act of 2003.

This study examined the impact of the demonstration in four areas:

1) The effect on premiums faced by beneficiaries;
2) The likelihood of beneficiaries switching plans as a result of higher premiums;
3) The likelihood of lower take-up of Part D; and
4) The costs to Medicare of the higher direct subsidies.

Due to the demonstration, Prescription Drug Plans (PDP) monthly premiums were $2.72 lower in 2007 and $0.57 lower in 2008. On average, the PDP premiums were 11% lower for PDP enrollees and 7% less for MA-PD enrollees in 2007. Beneficiaries rarely switched between plan types, but moved between benefit types (basic vs. enhanced), especially among Medicare Advantage Prescription Drug (MA-PD) program enrollees. When faced with premium increases, the vast majority of non-LIS (Low Income Subsidy) PDP beneficiaries still stayed in the same plan. About 130K beneficiaries would have switched to a lower cost plan without the demonstration. Take-up of Part D was minimally affected and an estimated 4,500 fewer beneficiaries would have enrolled in Part D without the demonstration.

The electronic version of the report is available here.

For more information, please contact Iris Wei at 410-786-6539 or Iris.Wei@cms.hhs.gov.

Evaluation of the MMA Section 702 Demonstration: Clarifying the Definition of Homebound: Supplementary Analysis

The MMA Section 702 demonstration was designed to test whether deeming severely disabled Medicare beneficiaries homebound for purposes of home health services eligibility would save Medicare costs and improve outcomes. CMS released the demonstration evaluation Report to Congress in January 2008. The evaluation found that a complex set of barriers hindered beneficiary participation in the demonstration, including concern among home health agencies that demonstration participants would be excessively costly to serve. The Office of Research, Development, and Information (ORDI) subsequently funded research on the role of payment outliers in the context of the evaluation findings. Analysis was motivated by the idea that if the characteristics of the demonstration target population and the outlier population overlap, then the demonstration concept may be viable and CMS's outlier policy could play a role in ensuring access to care for the demonstration target population. Using 2005 administrative data, analysts identified proxy demonstration patients in multiple states

and explored how they compared with patients who qualified for an outlier payment. While study groups are small, analysts found substantial differences between the two types of patients and the agencies that serve them. Results suggest that outlier payments are not being used to serve the types of severely, permanently disabled beneficiaries that were addressed by the demonstration concept.

For more information or to obtain a copy of the report, please contact Ann Meadow at 410-786-6602 or Ann.Meadow@cms.hhs.gov.

Evaluation of the Part D Payment Demonstration: Expenditures/Utilization and Medicare Payments Analysis

The primary goal of the Medicare Part D Payment Demonstrations was to increase the number of offerings of enhanced supplemental benefit plans with reduced cost sharing. This report presents the findings of the evaluation of the Medicare Part D reinsurance demonstration that analyzed Part D expenditure and utilization in demonstration versus non-demonstration plans to answer two key questions:

(1) Did the demonstration result in induced demand for Part D covered drugs?
(2) Did the demonstration result in higher Medicare reinsurance payments?

An electronic version is available here.

For more information, please contact Aman Bhandari at 410-786-2313 or Aman.Bhandari@cms.hhs.gov.

Evaluation of the Part D Payment Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries

CMS established a demonstration to phase in over three years the enrollment weighting methods for calculating the regional low income subsidy (LIS) benchmark premiums stipulated in the Medicare Modernization Act of 2003. This study examined the impact of the demonstration in four dimensions:

1) The effect on availability of at- or below-benchmark plans;
2) Beneficiary response to changes in plan availability;
3) The stability of drug utilization; and
4) Characteristics of demonstration-affected beneficiaries.

Higher regional benchmarks, combined with the de minimis policy, translated to greater numbers of zero-premium plans available in each region and thus reduced the number of full LIS beneficiaries subject to re-assignment in 2007 and in 2008. The vast majority (90%) of beneficiaries who received a re-assignment notification in November 2007 did not act on the letter and hence were enrolled into their re-assigned plan in January 2008. Compared to re-assigned beneficiaries, beneficiaries not subject to reassignment and

stayed in their original plan had a larger increase in both the average number of monthly Part D drug use and average drug costs between 2007 and 2008.

The electronic version of the report is available here.

For more information, please contact Iris Wei at 410-786-6539 or Iris.Wei@cms.hhs.gov.

Impact of Increased Financial Assistance to Medicare Advantage Plans: Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment in 2008

This report will present the overall findings from the study on the elements of the Medicare Advantage (MA) program implemented as a result of the Medicare Modernization Act (MMA) of 2003 that includes:

1) The Part D prescription drug benefit;
2) The regional preferred provider organization (PPO) plan type;
3) The more widely available special needs plans (SNPs); and
4) The Medical Savings Account (MSA) option.

While the report primarily focuses on 2008 MA plan availability, premiums, benefits, cost sharing, and enrollment, it also describes the trends relative to earlier years.

For more information or to obtain a copy of the report, please contact Melissa Montgomery at 410-786-7596 or Melissa.Montgomery@cms.hhs.gov.

Medicare Part D Program Evaluation: Analysis of the Impact of Medicare Part D on the FFS Program

The Medicare Part D benefit, established in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (P.L. 108-173), extended Drug coverage to an estimated 21.2 million beneficiaries. Improved access to prescription drugs can, in theory, improve beneficiary adherence to prescription medication regimens, improve beneficiary health, and potentially reduce the cost of other health services. The purpose of this research was to 1) produce descriptive statistics that relate Part D enrollment to beneficiary characteristics; and 2) to estimate the impact of Part D enrollment on Part A and Part B utilization and expenditures. The results of this research indicate that a little under half (45.7%) of fee-for-service (FFS) beneficiaries elected a Part D plan. There were substantively small but persistent indications that some older Medicare beneficiaries and beneficiaries diagnosed in prior years with costly chronic diseases were more likely to enroll in a Part D plan. Time series analyses found little evidence that implementation of Part D program had an impact on the Medicare spending and utilization under Parts A or B. Multivariate results seems to suggest that the impacts of Part D on Medicare FFS spending and utilization in the first year of the program (2006 data only) may not manifest in the aggregate, among the beneficiary population as a

whole and cause overall shifts in spending and utilization patterns. It seems more likely that impacts will be found among specific subpopulations and for targeted conditions.

The electronic version of the report is available here.

For more information, please contact Benjamin Howell at 410-786-6628 or Benjamin.Howell@cms.hhs.gov.

Monitoring Chronic Disease Care and Outcomes among Elderly Medicare Beneficiaries with Multiple Chronic Diseases: Activity 1

Researchers have pointed out that in 1999, 82% of elderly Americans had at least one chronic disease, 65% had 2 or more, 43% had 3 or more, and 24% had 4 or more. This situation has lead researchers to create various classification schemes to categorize co-morbid conditions using Medicare and other administrative data, as well as survey information. These classifications have been used to understand the impact of multiple acute and chronic conditions on various health services and health outcomes among the elderly. However, only a few researchers have examined the impact of having specific chronic diseases, such as diabetes and congestive heart failure or diabetes and chronic kidney disease, on subsequent mortality and certain clinical outcomes. Our study reports the rates of appropriate/recommended care for diabetes, and Medicare reimbursed preventive services among elderly Medicare beneficiaries with one, two, or three specific chronic diseases: diabetes, diabetes + depression, diabetes + chronic obstructive pulmonary disease (COPD), or diabetes + depression + COPD.

The electronic version of the report is available here.

For more information, please contact Pauline KariKari-Martin at 410-786-1040 or Pauline.Karikarimartin@cms.hhs.gov.

Monitoring Chronic Disease Care and Outcomes among Elderly Medicare Beneficiaries with Multiple Chronic Diseases: Activity 2

The authors report on the two-year mortality rates in 2003 and 2004, as well as the costs to Medicare in 2003, among elderly Medicare beneficiaries with one, two, or three of these diseases: diabetes, diabetes + chronic obstructive pulmonary disease (COPD), diabetes + major depression, or diabetes + COPD + major depression. Elderly beneficiaries having diabetes, COPD or major depression as of December 31, 2002 were identified using the CMS Chronic Condition Warehouse (CCW) database and categorized into cohorts having diabetes only (n=184,941), diabetes + COPD (n=23,793), diabetes + major depression (n=19,111) and diabetes + COPD + major depression (n=5,670). Bivariate and multivariate regression analyses were performed to compare mortality rates and costs between these groups. In addition, the mean cost per beneficiary in 2003 was tabulated for various types of Medicare reimbursed services. We found that the age-adjusted mortality rate was the lowest among persons with diabetes only (13.8 per 100).

It was 1.7 times greater for those with diabetes + depression (24.0 per 100); 2.2 times greater for those with diabetes + COPD (30.3 per 100); and 3.0 times greater for those with all three diseases (40.8 per 100). The mean per beneficiary cost to Medicare in 2003 varied almost 3-fold between the cohort with diabetes only ($9,052) and the cohort with all three diseases ($26,707).Intermediate in cost burden was the cohort with diabetes + depression ($14,647) and the cohort with diabetes + COPD ($18,756). The regression analysis using covariates that had the potential to influence the outcomes confirmed the mortality and cost findings. The most salient finding was the progressively decreasing odds of dying and of lower costs as the number of diabetes care services received increased. Those who received an HbA1c test, lipid test, and eye examination had approximately one-half the odds of dying compared with those who received none of these services. Depending on the cohort, the cost to Medicare of those who received all three tests was $3,300 to $9,540 less than among those who received none of these services. Among Medicare elderly beneficiaries with diabetes, there was a strong association of having COPD, depression, or COPD + depression with an increased probability of dying and increased cost to Medicare. The strong association we found between the use of diabetes care services and lower mortality rates and costs should be emphasized.

The electronic version of the report is available here.

For more information, please contact Pauline KariKari-Martin at 410-786-1040 or Pauline.Karikarimartin@cms.hhs.gov.

Part B Drug Payment Reform: Lower Expenditures without Signs of Adverse Effects

Congress passed payment reforms under the MMA of 2003 that included two major components:

1) They lowered the payment rates for Part B drugs and biologicals in 2004 from 95% to 85% of the average wholesale price (AWP); and in 2005, lowered payment further by initiating a new basis for payment—the average sales price (ASP) and set the reimbursement rate at 106% of ASP for most drugs.
2) They allowed for increases in the rates paid to physicians for drug administration in both 2004 and 2005.

CMS also substantially increased the inhalation drug dispensing fees paid to pharmacy-suppliers in 2004. Using Medicare claims data from 2000-2007, this study assessed the impact of the changes in payments for Part B covered drugs on beneficiaries, providers, and the distribution and delivery system for the drugs. The findings were generally encouraging for Medicare's change to an ASP-based payment system for Part B–covered drugs. The payment reforms appear to have controlled Medicare expenditures for Part B drugs and to have reduced beneficiaries' out-of-pocket liabilities for these drugs. Certain physician specialties saw reductions in their Medicare revenues, and users of specific

types of drugs experienced modest shifts in where they received their drugs, but there were no large-scale or broad-based changes in sites of drug administration.

The electronic version of the report is available here.

For more information, please contact Iris Wei at 410-786-6539 or Iris.Wei@cms.hhs.gov.

Premier Hospital Quality Incentive Demonstration Evaluation: Final Report

This report presents findings of the Premier Hospital Quality Incentive Demonstration (PHQID) for the period from October 2003 through September 2006. The PHQID offered participating hospitals financial incentives and public reporting to improve their quality of care. The report addresses whether paying incentives for high quality care would improve the quality of hospital inpatient care and reduce Medicare expenditures for care.

The electronic version of the report is available here.

For more information, please contact Linda Radey at 410-786-0399 or Linda.Radey@cms.hhs.gov.

Revision of Medicare Wage Index: Final Report – Part II

The Tax Relief and Health Care Act of 2006 (TRHCA) required the Medicare Payment Advisory Commission (MedPAC) to recommend alternatives for revising the hospital wage index. The TRHCA also required CMS to consider MedPAC's work in developing its own recommendations. Acumen, LLC has conducted an in-depth study of MedPAC's proposed index to assist CMS in meeting the TRHCA requirements. The Final Report is divided into two parts:

- Part I, released in May 2009, examines strengths and weaknesses of the wage data used to construct the proposed MedPAC index.
- Part II, released in March 2010, covers the methodology of wage index construction, with focus on the problems created by wage area boundaries.

Part II analyzes MedPAC's proposed method of defining the wage areas used in the current Medicare wage index. This method first "blends" metropolitan statistical area (MSA) and county-level wages and then implements a "smoothing" step which, as proposed by MedPAC, limits differences in wage index values between adjacent counties to no more than 10% (Acumen also analyzed 5% and 15% thresholds). With this smoothing algorithm, counties can only be adjusted upward toward the wage index value of adjacent counties. MedPAC reduces all the post-smoothing wage index values to achieve budget neutrality.

One characteristic of MedPAC's smoothing adjustment is that it creates "ripple effects" on wage index values of additional counties not affected by the first smoothing adjustment. The more ripple effects occur, the greater the required budget neutrality adjustment and the larger the number of hospitals whose wage indexes are only (negatively) affected by budget neutrality. Depending on the threshold set for the maximum allowable cliff, there is a tradeoff between the reduction in the average cliff size and the extent of ripple effects. Budget neutrality decreases wage index values for hospitals that did not receive a smoothing adjustment, and this effect is larger the lower the smoothing threshold.

Acumen's analysis suggests that certain hospitals currently receiving reclassifications and exceptions (e.g., rural hospitals) would benefit less from the MedPAC blending and smoothing method than they do from the current system of reclassifications and exceptions. This result does not imply that the current system of reclassification and exceptions necessarily is better than MedPAC's blending and smoothing method in matching hospitals' wage index values and the prevailing wages in their labor market. Acumen recommends further exploration of labor market definitions using a wage area framework based on hospital-specific characteristics, such as the commuting times from hospitals to population centers, to construct a more accurate hospital wage index.

For more information or to obtain a copy of the report, please contact Craig Caplan at 410-786-4165 or Craig.Caplan@cms.hhs.gov.

6. Current Demonstrations and Research Projects

Home Health Pay for Performance Demonstration

The Centers for Medicare & Medicaid Services (CMS) shared more than $15 million in savings with 166 home health agencies (HHAs) based on their performance during the first year of the Medicare Home Health Pay for Performance (HHP4P) demonstration.

All Medicare-certified home health agencies in seven states representing four U.S. census regions were invited to participate in the demonstration. Participants in the Northeast region included HHAs in Connecticut and Massachusetts, the South included HHAs in Alabama, Georgia, and Tennessee, and the Midwest and West regions included HHAs in Illinois and California, respectively.

For more information about the demonstration, please email questions to hhp4p@cms.hhs.gov or visit the demonstration web site here.

Medicare Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration

On June 3, 2010, Health and Human Services' Secretary, Kathleen Sebelius announced the beginning of the solicitation period for the Multi-payer Advanced Primary Care

Practice (MAPCP) Demonstration. Under this three-year demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas.

Advanced primary care (APC) practices, or "medical homes," utilize a team approach to care, with the patient at the center. APC practices emphasize prevention, health information technology, care coordination, and shared decision making among patients and their providers. The goal is to improve the quality and coordination of health care services.

States conducting multi-payer APC initiatives are eligible to apply for the demonstration. To qualify for participation, the State initiatives must:

- Be conducted under state auspices;
- Have promotion of the APC model as its central purpose;
- Include Medicaid and substantial participation by private health plans;
- Have substantial support by primary care providers;
- Include mechanisms for community support of participating practices; and
- Be coordinated with state health promotion and disease prevention efforts.

CMS plans to enter into cooperative agreements with six states as part of this demonstration. Applications for the demonstration are due August 3, 2010 and we expect to announce the selected sites later this fall.

For more information about the demonstration, including a copy of the press release as well as the application requirements, see the demonstration web site here.

7. Medicare Part B National and Carrier Data Files are Now Downloadable

In support of the Open Gov Initiative, the Part B National and Carrier files are now available as free downloads. The Part B National data files for years 2000 through 2008 are posted here and the Part B Carrier data files for years 2005 through 2008 are posted here.

In regards to these files, please note the following:

- Prior to downloading a data file, you must read and agree to the AMA copyright statement, which is referred to as the AMA click agreement.
- The CMS privacy rules for cell size suppression apply to the Carrier data so cell sizes of 10 or less need to be omitted. The CMS privacy rules do not apply to the National data.

- The data files will also be available for a fee for those that prefer to purchase the CD. The order form will state that they are available as free downloads.

For more information, please contact Debbie Pusateri at 410-786-0171 or Deborah.Pusateri@cms.hhs.gov.

8. Data Files Present on Data.Gov

The http://www.data.gov website is celebrating its one-year anniversary and CMS continues to identify and make data files available from this site. The three types of data catalogs available are Raw Data, Tool, and Geodata. Of the seventy-two datasets in the Raw Data catalog, the Office of Research, Development, and Information (ORDI) posted seventy-one that include sixty-two datasets in the Medicare Cost Reports and nine datasets in the Part B National files. There are twenty-two datasets posted in the Tool catalog. Five of the datasets from the tool catalog include ORDI-related publications including *The Medicare and Medicaid Statistical Supplement*, *The Data Compendium*, *The CMS Statistics Booklet*, *The Wallet Card*, and *The Medicare Short-Stay Hospital Utilization* (which points to *The CMS Statistics Booklet*). Along with the datasets submitted above, the Part B Carrier files also were submitted as candidates for the Raw Data catalog. Currently, CMS does not have datasets for the Geodata catalog.

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