Below please find the Winter 2008-2009 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 Winter 2008-2009 edition of the *Health Care Financing Review*, CMS' journal of information, analysis, and research on a broad range of issues affecting the Medicare, Medicaid, and Children's Health Insurance (CHIP) programs. The theme of this issue is Psychosocial Services in Long-Term Care.
- Release of the 2008 *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, along with the 2008 *Data Compendium*.
- Online availability of the 2009 *Active Projects Report*, an annual compilation listing the demonstrations, evaluations, and research projects that CMS supports in pursuit of better health care for our beneficiaries.
- Briefing at the National Press Club.
- New research reports.
- Program demonstrations and research projects. ORDI is developing and managing a number of demonstrations and research projects for CMS, some of which are summarized below.

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*

Since our last newsletter, ORDI released the Winter 2008-2009 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. The theme of this issue is Psychosocial Services in Long-Term Care. Included are articles on understanding and improving psychosocial services in long-term care, effects of Green House® nursing homes on residents' families, and facility services environments, staffing, and psychosocial care in nursing homes. Also included are articles are Medicare risk adjustment for the frail elderly, cost of lifetime immunosuppression coverage for kidney

transplant recipients, and alternative comorbidity adjustors for the Medicare inpatient psychiatric facility PPS. Click **here** to view the Winter edition, as well as previous issues.

To request copies of the printed edition, please contact Patty Manger at 410-786-3253.

2. *Health Care Financing Review: Medicaid & Medicare Statistical Supplement*

The 2008 edition of the annual *Statistical Supplement* is now available on the CMS web site. The *Statistical Supplement* includes tables showing health expenditures for the entire U.S. population, characteristics of the covered populations, use of services, and expenditures under these programs. The 2008 edition, as well as earlier editions, is available **here**.

For more information, please contact Debbie Kidd at 410-786-7204.

3. *Data Compendium*

The *Data Compendium* is an annual publication providing key statistics about CMS programs and health care spending. The *Compendium* contains historic, current, and projected data on Medicare and Medicaid enrollment, expenditures, and utilization. Data pertaining to budget, administrative, and operating costs, individual income, financing, and health care providers and suppliers are also included. Both the current edition of the *Compendium* and editions from previous years can be found **here**.

For more information, please contact Maria Diacogiannis at 410-786-0178.

4. *Active Projects Report*

The 2009 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. It 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.

5. Briefing at the National Press Club

Health Affairs hosted a briefing, "Chronic Illness: Can We Reform and Rethink Prevention?," at the National Press Club in Washington, D.C., on January 6 to announce the publication of its January-February special issue devoted to the crisis in chronic disease. The briefing consisted of three panels to discuss issues related to out-of-pocket

spending, prevention and lessons learned from various disease management initiatives. ORDI's David Bott, Ph.D. served as a panelist to discuss lessons learned from Medicare's disease management activities. Dr. Bott, lead author, along with Mary Kapp, Lorraine Johnson, and Linda Magno, who are also ORDI staff, on a paper in the *Health Affairs* issue, summarized findings from CMS' experience with disease management initiatives in fee-for-service Medicare over the past decade, indicating that the agency has not found any broad or dramatic success within these initiatives. However, CMS has extended 7 of the 35 programs that have shown some promise.

Health Affairs has made an audio recording of the event and the PowerPoint slides from presentations available **here**. The chronic disease issue of *Health Affairs*, which includes free and paid-access articles, is available online **http://content.healthaffairs.org/content/vol28/issue1/**.

For more information, please contact Dave Bott at x 60249.

6. New Research Reports

"Monitoring Chronic Disease Care and Outcomes among Elderly Medicare Beneficiaries with Multiple Chronic Diseases: Appropriate Diabetes Care and Prevention for Diabetes, Depression and/or COPD" A. Marshall McBean, Deb Caldwell, Kyoungrae Jung, and Jee-Ae Kim, University of Minnesota

The purpose of this study was to examine the extent to which elderly Medicare beneficiaries with multiple chronic conditions received recommended care and preventative services and to determine whether each additional condition had an impact on whether the beneficiaries received those services.

The following chronic diseases and disease combinations were considered: diabetes; diabetes and depression; diabetes and chronic obstructive pulmonary disease (COPD); and diabetes and depression and COPD. The study outcomes included three diabetes care measures (serum hemoglobin A1c (HbA1c) testing, lipid (LDL-C) testing, and eye examination), as well as three preventive care measures that are recommended for all elderly beneficiaries (or one sex): influenza immunization, mammography, and screening prostate specific antigen (PSA) testing. Rates of screenings and preventative care services were determined and multivariate logistic regression analyses were carried out to examine the effect of additional disease burden on the rate of receipt diabetes care and preventive care services. Baseline age-adjusted rates among Medicare beneficiaries with diabetes were as follows: HbA1c test (72.9 percent), lipid testing (66.5 percent), eye examination (50.7 percent), influenza vaccination (54.7 percent), mammogram among women (45.4 percent), and PSA test among men (42 percent). Across all measures, rates generally became lower among beneficiaries with diabetes and COPD, and even lower among those with diabetes, COPD, and depression, a set of findings that was also supported by the regression analyses. Results were more variable among those with diabetes and depression, but not COPD.

For more information, contact Karyn Kai Anderson, Ph.D., M.P.H., at 410-786-6696.

"Monitoring Chronic Disease Care and Outcomes among Elderly Medicare Beneficiaries with Multiple Chronic Diseases: Costs of Care and Mortality"

This study examined the 2-year mortality rates (2003 and 2004) and the costs to Medicare (2003) among elderly Medicare beneficiaries with multiple chronic conditions. The following chronic diseases and disease combinations were considered: diabetes; diabetes and depression; diabetes and chronic obstructive pulmonary disease (COPD); and diabetes and depression and COPD. Multivariate regression analyses were carried out for each disease cohort, as well as all cohorts combined, in order to examine the effect of adding additional disease burden on mortality and costs.

The mean per beneficiary cost to Medicare in 2003 varied almost threefold between the cohort with diabetes only ($9,052) and diabetes, COPD, and depression ($26,707) with intermediate cost burdens of $14,647 for those with diabetes and depression and $18,756 for those with diabetes and COPD. A key cost-related finding is that the receipt of diabetes care services was strongly related to lower costs to Medicare for all four cohorts of beneficiaries. Compared with those diagnosed with diabetes only, there was a 75 percent greater likelihood of dying within 2 years among those with diabetes and COPD, and the risk was more than double for those with diabetes, COPD, and depression. As the number of diabetes care services increased, a beneficiary's odds of dying decreased. Those who had received all three diabetes care measures (serum hemoglobin A1c (HbA1c) testing, lipid (LDL-C) testing, and eye examination) reduced their odds of dying in half, compared with those who had received none of these services.

For more information, contact Karyn Kai Anderson, Ph.D., M.P.H., at 410-786-6696.

"LifeMasters Disease Management Demonstration Evaluation: Final Report"

The LifeMasters program began providing disease management services to targeted dual eligible Medicare fee-for-service beneficiaries with congestive heard failure (CHF), diabetes, or coronary artery disease (CAD), who resided in certain counties in Florida. The demonstration began January 2005 and is still operational. The intervention is primarily telephonic and includes the use of web-based technology. This demonstration incorporates a population-based randomized control group design. Beneficiaries assigned to the treatment group receive disease management interventions while those in the control group receive usual care.

During the first 2 years of operation, it became evident that the LifeMasters program was not yielding savings to sufficiently cover its fee. In response to this finding, LifeMasters, with approval of CMS, redesigned its program to continue to provide services to beneficiaries in 7 of the 11 original counties and focus their intervention on patients with CHF, and any combination of CHF, CAD, or diabetes. Redesign efforts began in March 2007 and are monitored closely by CMS. Per the redesign, beneficiaries with stand-alone diabetes or CAD, and beneficiaries in the counties no longer being served by LifeMasters were dropped from the demonstration.

The evaluation assesses the effectiveness of the demonstration in improving health outcomes and reducing costs. The final evaluation report covers the first 3 years of the demonstration (1/1/05-12/31/07), including the first 10 months of the 'redesign' period. Program effects on two separate cohorts were assessed: (1) all the beneficiaries served by LifeMasters from January 2005 through December 2007, and (2) the new redesign cohort.

Overall, impacts of the program were small and inconsistent. There were no treatment control differences in Part A Medicare services (hospitalization, ER use, readmissions) or total Medicare expenditures. The program appeared to have reduced some Part B expenditures (lab and radiology services) during the second year of enrollment, and outpatient and home health services during the third year. Third year results primarily reflect patients in the redesign population. Results of the beneficiary survey indicated a few differences between the treatment and control groups: treatment group members were more likely to report greater awareness of how to take medications, and more assistance with transportation.

For more information, contact Lorraine Johnson at 410-786-9457.

"Prototype Medicare Resource Utilization Report Based on Episode Groupers"

In response to rapidly rising Medicare costs, CMS has undertaken efforts to stem this increase by exploring a variety of value-based purchasing initiatives aimed at containing costs while improving the quality of care for Medicare beneficiaries. A key initial goal of these efforts consists of providing feedback and education to encourage less costly practice by physicians and hospitals. This report, prepared by Acumen, LLC, documents development of a prototype resource utilization report for physicians participating in the Medicare fee-for-service system based on claims data from the Parts A and B programs. The report addresses several questions in estimating efficiency "scores" of providers and rank providers in meaningful comparison groups:

- How should Medicare costs be apportioned into episodes of care?
- Which providers are eligible for the assignment of costs?
- How should episode costs be attributed to eligible physicians?
- How many episodes are required to develop a score for a physician treating a specific illness?
- What is the relevant peer group for a provider?

Application of the prototype reveals effects on resource use estimates of methods used to construct episodes of care for purposes of estimating resource use, rules used to assign resource use to providers, and peer groups against which providers are compared.

The report is available **here.** For more information, please contact Fred Thomas at 410-786-6675.

"Evaluation of Phase I of the Medicare Health Support Pilot Program Under Traditional Fee-for-service Medicare: 18-Month Interim Analysis" by Nancy McCall, Jerry Cromwell, Carol Urato, and Donna Rabiner, RTI International.

This is the second Report to Congress on Medicare Health Support (MHS) and covers the first 18 months of the 3-year Phase I pilot. It contains an update on the implementation of the programs and findings with respect to following measures: quality improvement, beneficiary satisfaction, health outcomes, and financial outcomes. Two programs showed improvement in beneficiary satisfaction. There was limited effect in improving self-management, physical and mental health functioning, and quality of care. The interventions did not reduce utilization or mortality. In the first 18 months of operations, four of the programs have achieved only modest progress toward achieving targets for savings to the Medicare program, far less than their management fees. The other four programs show no decrease in Medicare claims costs.

The report is available **here**. For more information, contact Mary Kapp at 410-786-0360.

"Evaluation of Medical Savings Account Plans under the Medicare Program: Focus Group Report"

This is the second of three reports on the evaluation of medical saving account (MSA) plans offered under the Medicare program. The report presents findings from focus groups and telephone interviews with beneficiaries, physicians, State Health Insurance Assistance Program (SHIP) counselors, and insurance brokers and agents and gathered information about their attitudes, knowledge and experience with MSA plans. Cost was the most significant draw to the MSA plans, especially the lack of monthly premiums. MSA enrollees generally rated their MSA plans highly, but expressed dissatisfaction with certain aspects of the plans, including the bank component (e.g., delays in deposits, checks, and debit cards and monthly fees), claims processing, and the plan's impact on their relationships with the physicians (e.g., uncertainties about what how the plan worked and what was covered along with uncertainties about provider payment). With some of the initial issues addressed, however, nearly all of the MSA participants indicated that they would continue with their plans. Insurance brokers and agents played an essential role in informing and enrolling beneficiaries in the plans. Respondents tended to have mixed reactions to the lack of prescription drug coverage in the MSA plans. Lack of first dollar coverage for preventive services was seen as a major disadvantage by the brokers, but was seldom cited as an issue among other participants. The report provides some suggestions for improving the MSA plans.

For more information, please contact Melissa Montgomery at 410-786-7596.

"Evaluation of the Erickson Advantage Continuing Care Retirement Community Demonstration: Final Report"

Seeking to provide innovative and effective services that address the current and evolving needs of Medicare beneficiaries, CMS sponsored an evaluation of the Erickson Advantage Continuing Care Retirement Community (CCRC) demonstration. In 2005, a

demonstration program was set up, creating a Medicare Advantage (MA) plan exclusively within the Erickson CCRCs and managed by Evercare/UnitedHealth Group. Pacific Consulting Group and the University of Minnesota examined the effect of the community integrity waiver to help CMS develop the criteria needed to establish MA plans that are limited to residential settings but do not encourage selection bias for low-risk enrollees.

The evaluation used case studies, focus groups, and secondary data analyses to understand how services are provided within the Erickson CCRC and the innovations in the organization and delivery of care by the Erickson Advantage (EA) plan. Erickson residents gave feedback on their experiences with and perceptions of the health care provided within the CCRC and the EA plan. The evaluation analyzed differences in demographics and disease burden both within the Erickson population and between Erickson residents and the surrounding communities. While differences in demographics and disease burden were identified, EA's outcomes or effects on utilization and costs were not evaluated.

Selected findings

- Erickson has a strong, resident-centered organizational culture, which is reflected at every level. They actively seek feedback and suggestions from residents and are innovative and improvement-oriented. Erickson develops and pilots new features and services at individual sites before implementing them campus-wide.
- Participants were very satisfied with the quality of care provided by the on-site physicians regardless of their enrollment in Erickson Advantage.
- Erickson residents have higher disease burden than their counterparts in the community, even when the data are age-, race-, and gender-adjusted.
- Within Erickson, EA members have lower age-, race-, and gender-adjusted Hierarchical Condition Category scores than their Erickson fee-for-service counterparts.
- No clear evidence of selection bias favoring EA.

This report is available **here**. For more information, please contact Gerald Riley at 410-786-6699.

"Evaluation of Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration Third Annual Report: Results of the Medicare Health Services Survey"

This report presents the results of the Medicare Health Services Survey that is one of the components of the overall CMHCB evaluation conducted by RTI International. RTI surveyed a sample of beneficiaries in each of the six programs separately to determine the impact of the intervention on physical functioning, mental functioning, self-care behaviors, and beneficiary experiences with care.

Following are the primary research questions addressed by the beneficiary survey:

- Does the CMHCB program help beneficiaries to cope better than beneficiaries in the comparison group with their chronic conditions?

- Does the program improve self-management behavior?
- Does the CMHCB program result in better physical and mental functioning than would otherwise be expected?

Program effects are estimated by comparing the experiences of intervention group members to those for randomized controls or matched comparison group beneficiaries. Further, the overall design of the CMHCB demonstration follows an intent-to-treat model, so that the underlying population for the survey sample included all beneficiaries assigned to the intervention regardless of their level of participation in the demonstration program. For that reason, the survey contained measures relevant to all beneficiaries in the demonstration regardless of their intervention or control/comparison group status.

Overall, the findings show that beneficiaries in the CMHCB intervention groups did not report more favorable experiences getting help to set goals, create a care plan, or cope with a chronic condition compared with the control groups. With only few exceptions, the interventions had little impact on the frequency of self-care activities or self-efficacy to perform these activities. RTI also did not find consistent significant differences in beneficiary physical and mental functioning with the exception of two programs where beneficiaries reported better physical health and another where beneficiaries reported fewer depressive symptoms. The focus of the CMHCB demonstration interventions was largely on impacting beneficiary behavior to better manage their chronic illness. Yet these results show little evidence of changes in self-efficacy or self-care.

The report is available **here**. For more information, please contact David Bott at 410-786-0249.

"Applying the 2003 Beers Update to Medicaid/Medicare Enrollees"

This paper, by ORDI staff Steven Blackwell, Gary Ciborowski, David Baugh, and Melissa Montgomery, was published in the *International Journal of Pharmaceutical and Healthcare Marketing*, volume 2, number 4, 2008. This study examines variations in Beers drug use in the elderly dually eligible Medicare and Medicaid population in 2003 by applying the 2003 Fick *et al*. update of the 1997 Beers list to one of the nation's largest sources of person-specific data on prescribed drugs. The authors use a cross sectional retrospective review of the 2003 CMS Medicaid Pharmacy claims data. Potentially inappropriate drug use was assessed using the 2003 Fick update to the previous 1997 Beers list. Inappropriate use was identified based on these criteria for drugs independent of diagnosis.

Of enrollees with drug use, 34 percent received an inappropriate drug per the 1997 Beers list; 47 percent per the 2003 Fick update. Hispanics had the highest percentage of drug recipients receiving an inappropriate drug in the Northeast region per the 2003 Fick update. Within therapeutic category, the number of inappropriate genitourinary products dispensed to total genitourinary products ranked the highest at 20 percent per the 2003 Fick update. The authors found that a markedly higher rate of potentially inappropriate drug use in the elderly Medicaid population exists following the Fick update. The findings provide evidence that the potential use of inappropriate drugs in Hispanics

should be considered separately from other ethnicity groups. By comparing drug use based on therapeutic category, genitourinary products were found to have the highest potential for inappropriate prescribing.

For additional information or to obtain a copy of the report, please contact Steve Blackwell at 410-786-6852

"Evaluation of the Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities - Report to Congress"

In Section 122 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Congress mandated that the Department conduct demonstrations aimed at reducing disparities in screening, diagnosis, and treatment of cancer among racial and ethnic minority Medicare-insured beneficiaries. Six sites were selected for this demonstration, named the Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities, each focusing on a distinct minority group (African Americans, 2 sites; Hispanic, 2 sites; American Indians, 1 site; Asian Pacific Islanders, 1 site).

The demonstration tests the effectiveness of a patient navigation model in reducing disparities and reducing Medicare costs. This report summarizes the first year of implementation, based on in-person site visits and document review. Five sites encountered difficulties with identifying eligible beneficiaries and enrolling them in the demonstration, resulting in substantially fewer participants than initially projected. This report also includes claims-based analyses of disparities in cancer screening across all sites. African American, Hispanic, Asian Pacific Islander, and American Indian/Alaska Native Medicare beneficiaries were all significantly less likely to have received these tests during the year in comparison with white Medicare beneficiaries.

The report is available **here**. For more information, contact Karyn Kai Anderson, Ph.D., M.P.H., at 66696.

Report to Congress: Best Practices for Enrolling Low-Income Beneficiaries Into the Medicare Prescription Drug Benefit Program

in January, the Report to Congress was submitted as required by the Conference Report accompanying the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS contracted with Mathematica Policy Research to conduct the study designed to understand what particular activities (outreach, partnerships, involvement of key organizations, or others) and at what level (Federal, State, local) contribute to effectively enrolling and transitioning limited income beneficiaries into Part D plans and the low-income subsidy (LIS) programs. Participants in the various qualitative data collection activities consistently identified best practices for each step of the process -- from identifying potential individuals eligible for LIS application, to conducting outreach and education, and providing assistance with Part D plan decision making. Three fundamental elements including a strong reliance on community-based organizations (CBOs), establishment of an infrastructure to support CBO efforts, and formation of partnerships improved the chances for the best practices to be effective.

For more information, contact Noemi Rudolph at 410-786-6662

"Report to Congress—Evaluation of the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals"

The Report to Congress addresses the impact of CAP on: the range of contractors; drug prices compared to prices under standard Part B drug payments; programmatic savings; reductions in cost-sharing; access to drugs; the satisfaction of beneficiaries; and physician satisfaction.

- **Range of vendors:** Many vendors participated in the initial bidding process, only one vendor elected to complete the final contracting step. The designation of a single vendor in the context of a competitive acquisition program may not represent a poor choice for CAP-electing practices because the price reducing effects of competition at the bidding stage may in part still be realized.
- **Prices and Programmatic Savings:** CAP prices for drugs administered by participating physicians were slightly higher than under the 106 percent of the average sales price (ASP) alternative. For the first 18 months of physician participation in the CAP, CAP prices, on average, slightly exceeded 106 percent of the ASPs for CAP drugs. Over the 30-month period of the first vendor contract, it is expected that the CAP will be approximately budget neutral.
- **Cost-sharing and Beneficiary Satisfaction:** Because prices under the CAP were similar to the ASP method, co-payments did not vary much. Beneficiaries generally reported few problems associated with the CAP program and with the vendor.
- **Beneficiary Access to Drugs:** Beneficiaries reported few drug availability problems associated with the CAP.
- **Physician Satisfaction:** Although a large proportion (45 percent) of the practices participating in the CAP in 2006 opted not to participate in 2007, an even larger number of practices newly elected the CAP in 2007. The total number of participating practices rose to 938 (representing a total of 3,247 physicians, several times the number of physicians who participated initially). This may indicate interest in the program for these practices.

For more information, please contact Jesse Levy at 410-786-6600.

"Report to Congress—Geographic Variation in Drug Prices and Spending in the Part D Program"

This Report to Congress examines the extent of variation in per capita spending for covered Part D drugs and identifies the amount of that variation that is attributable to price variation and differences in utilization not accounted for through health status risk adjustment. The report also includes recommendations regarding the appropriateness of applying a geographic adjustment factor to the national average bid amount.

We find that there is very little price variation across the 34 prescription drug plan (PDP) regions. When the indices are constructed for unique drugs (as defined by the National Drug Code), the greatest variation for any regional price index from the national index is

2 percent. The findings of this study indicate that there is modest regional variation in median per-capita spending in the community population. The highest annual per-capita expenditure was observed in Alaska, New Jersey, and New York, and the lowest annual per-capita expenditure observed in the territories. Much of this regional variation exists even after accounting for health status and geographic differences in drug prices. Although we have found some variation, we believe that implementing an adjustment to the national average monthly bid amount to reflect regional variations in utilization beyond that which is due to differences in health status would interfere with the competitive nature of the Part D program and inappropriately reward Part D plans and beneficiaries in PDP regions with higher drug utilization.

Based upon these findings, we recommend that it would not be appropriate to adjust the direct subsidy for Part D plan sponsors based upon region and that it would not be appropriate to apply a geographic adjustment factor to the national average bid amount.

For more information, please contact Jesse Levy at 410-786-6600.

7. Current Demonstrations and Research Projects

End Stage Renal Disease (ESRD) Disease Management Demonstration

The ESRD Disease Management Demonstration, operating since 2006, includes three organizations – DaVita, Evercare, and Fresenius – who, along with Medicare Advantage (MA) partners, have provided and coordinated services for ESRD patients. The demonstration has an innovative pay-for-performance feature. To be rewarded from a performance pool, the demonstration participants must meet targets for six clinical indicators that are significant for dialysis patients. There are two distinct targets for each indicator: an improvement target, according to which clinical results must increase (or decrease) compared to the previous year's performance; and a national target, whereby they must improve over nationwide percentages.

ORDI recently notified the participating organizations on their performance for the demonstration's third 6-month period, from January to June 2007. The third period results are notable in that overall the three organizations moved toward higher levels, meeting more of the improvement targets. All three organizations have a perfect record on the national targets.

Working with Arbor Research, its contractor, ORDI has successfully operationalized pay-for-performance for the ESRD Disease Management Demonstration. These efforts and lessons learned serve as a source of experience and instruction for future CMS endeavors in pay-for-performance for ESRD.

For additional information, please contact Ron Deacon, 410-786-6622.

Previous Listserv newsletters are available under the heading “ORDI Research News Listserv Archive” **here**.

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