Below please find the Summer 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 Summer 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.
- The 2009 version of the CMS Statistics Handbook and Wallet Card.
- 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 Summer 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, estimating costs of potentially preventable hospital acquired complications, refinement of the Medicare Hospice Payment System, and redesigning the Medicare Inpatient PPS to reduce payments to hospitals with high readmission rates.

Click here to view the Summer 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 additional information, 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 additional information, please contact Maria Diacogiannis at 410-786-0178 or maria.diacogiannis@cms.hhs.gov.

4. Published Articles

Administrative and Claims Records as Sources of Health Care Cost Data

Author: Gerald F. Riley, M.S.P.H.
Publication: Medical Care; Volume 47, Number 7, Supplement 1, July 2009: pp. S51-S55.

Many economic studies of disease require cost data at the person level to identify diagnosed cases and to capture the type and timing of specific services. One source of cost data is claims and other administrative records associated with health insurance programs and health care providers. This article describes and compares the strengths and limitations of various administrative and claims databases.

Administrative data are often available for large, enrolled populations, have detailed information on individual service use, and can be aggregated by service type, episode, and patient. Service use and costs can often be tracked longitudinally. Because they are not collected for research purposes, administrative data can be difficult to access and use. Limitations include generalizability, complexity, coverage and benefit restrictions, and lack of coverage continuity. Linked datasets permit identification of incident cases of disease, and analyses of health care costs by stage at diagnosis, phase of care, comorbidity status, income, and insurance status.

Administrative data are an essential source of information for studies of the financial burden of disease. Cost estimates can vary substantially by specific measures (payments, charges, cost-to-charge ratios) and across data sources.

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

5. New Research Reports

Analysis of 2006-2007 Home Health Case-mix Change: Final Report

Since 2008, CMS has reduced the Medicare home health prospective payment system rates in two consecutive years in order to offset the effects of nominal coding change. In its 2008 regulation, CMS indicated an intention to update analyses quantifying the amount of billed case mix increase that could lead to offsetting rate reductions (Federal Register CMS-1541-FC). This report details the data and methods used in the first update of the case mix change analysis. The results identified 9.77% of the total change in billed case mix between Fiscal Year 2000 and Calendar Year 2007 as real case mix change, with the remainder of the total change identified as nominal coding change. Findings of the report were the basis for proposals discussed in CMS' notice of proposed rulemaking, published on August 6, 2009 (Federal Register CMS-1560-P, revised August 13, 2009).

The electronic version of the report is available here. For additional information, please contact Ann Meadow at 410-786-6602 or ann.meadow@cms.hhs.gov.

Developing Outpatient Therapy Payment Alternatives (DOTPA): 2009 Project Annual Report

The purposes of this project are to identify, collect, and analyze therapy-related information tied to beneficiary need and the effectiveness of outpatient therapy services. The 2009 annual project report includes a high-level analysis of the utilization of and expenditures for outpatient therapy services using CMS claims from the most recently available calendar year, 2007. For a copy of the complete report you may visit the project website at http://optherapy.rti.org/. Key results from the analysis include:

- Medicare expenditures for outpatient therapy were over $4.3 billion in CY 2007, representing a 6.6 percent increase from CY 2006.
- Almost three-quarters (74 percent) of the CY 2007 expenditures were for Physical Therapy (PT), 19 percent for Occupational Therapy (OT), and 7 percent for Speech Language Pathology (SLP).

- The distribution of the settings providing outpatient therapy has shifted in the last few years away from facilities (hospitals, etc.) and physician offices and toward therapists in private practice (PTPP and OTPP). From 2006 to 2007, there was more than a 16 percent decrease in the number of comprehensive outpatient and rehabilitation facilities (CORFs) and home health agencies (HHAs), while the number of PTPPs and OTPPs increased by 8 percent.
- Almost 95 percent of all outpatient therapy claim lines and Medicare payments in both CY 2006 and CY 2007 were represented by just 15 Healthcare Common Procedure Coding System (HCPCS) codes. The importance of each of these procedures varied across provider settings.

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

Evaluation of the Background Check Pilot Program: Final Report

This Final Report responds to Section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that requires the Secretary of the Department of Health and Human Services, in consultation with the Attorney General, to conduct an evaluation of the Background Check Pilot Program. The evaluation study was to recommend procedures and payment mechanisms for a national criminal background check program implemented by long-term care providers to check prospective employees who would have direct patient access. Seven States participated in the pilot program: Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. The pilot program ended on September 30, 2007. The final report presents the findings and considerations from the evaluation. In general, the pilot States felt the MMA pilot model legislation struck an appropriate balance between the mandated core requirements and State flexibility. The evaluation considerations include allowing a check to be valid for 1-3 years, rather than for each potential new hire. Of the 204,356 applicants, 7,453 (3.6 percent) were disqualified, with an additional unknown number deterred because they knew that they would be disqualified. There was no consensus on how or who should pay for this program. However, if Medicare and Medicaid are deemed appropriate payors, allocation of costs should be based on program participation. Medicare would need statutory authorization to consider these costs in its rate-setting process. Three-year national program cost estimates ranged from $314-$859 million (fee-based), to $503-$871 million (resource use-based).

The electronic version of the report is available here. For additional information, please contact M. Beth Benedict, Dr.P.H., J.D., at 410-786-7724 or beth.benedict@cms.hhs.gov.

Evaluation of Medicare Disease Management Programs: LifeMasters Final Report of Findings

The LifeMasters program began providing disease management services to targeted dual eligible Medicare fee-for-service beneficiaries in 11 counties in Florida with congestive

heart failure (CHF), diabetes, or coronary artery disease (CAD) with the goal of improving health outcomes and reducing cost. The demonstration began January 2005. A population-based randomized control group design was used. In January 2007, LifeMasters, requested and received CMS approval to redesign its program and continue to provide services only 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. This effort began March 2007

Overall impacts were scattered, small and inconsistent. There were no treatment control differences in part A Medicare services (hospitalization, emergency room use, readmissions) or total Medicare expenditures. The program appeared to have reduced some Part B expenditures (lab and radiology services) in the second year of enrollment, and in the third year, outpatient and home health services. The third year included mostly patients in the redesign population and may be budget neutral only for the redesign population. Separate analysis indicated that the redesign population was driving the Part B savings. Results from the beneficiary survey indicated a few favorable differences between the treatment and control groups that may represent true impacts: the treatment group members were more likely to report receiving more assistance with transportation, and more help with arranging care.

Although the demonstration was extended for an additional 3 years on January 1, 2008, each year was contingent on prior year performance. It was terminated because, based on preliminary estimates, LifeMasters incurred a liability of approximately $87,000,000.

The electronic version of the report is available here. For more information, please contact Lorraine Johnson at 410-786-9457 or lorraine.johnson@cms.hhs.gov.

Evaluation of the Medicare Lifestyle Modification Program Demonstration and the Medicare Cardiac Rehabilitation Benefit

ORDI posted reports related to the evaluation of the Medicare Lifestyle Modification Program Demonstration and the Medicare Cardiac Rehabilitation Benefit on the CMS website. The Medicare Lifestyle Modification Program Demonstration was conducted from October 1999 through February 2007, to test the efficacy and cost-effectiveness of two cardiovascular lifestyle modification programs: the Dr. Dean Ornish Program for Reversing Heart Disease® (Ornish) of the Preventive Medicine Research Institute and the Cardiac Wellness Program of the Benson-Henry Mind/Body Medical Institute (M/BMI). Each lifestyle program consisted of a 1-year treatment program that included supervised exercise, nutrition counseling, stress management, and group support beginning with a 3-month period of intensive supervised interventions followed by 9 months of less frequent sessions with a greater emphasis on home maintenance of healthy behaviors. The two programs differed to some degree in the content and intensity of the intervention.

Brandeis University conducted the evaluation to assess the feasibility, outcomes, cost, and cost-effectiveness of providing payment for these comprehensive cardiovascular lifestyle modification program services to Medicare beneficiaries. The evaluation also

included a meta-analysis of all lifestyle modification program published research and an evaluation of the Medicare cardiac rehabilitation program. The evaluation revealed a low uptake of the lifestyle modification programs tested in this demonstration, as well as the Medicare cardiac rehabilitation benefit. Over the life of the demonstration, the Ornish sites enrolled 147 participants and the M/BMI sites 442. A total of 373 beneficiaries (89 Ornish, 284 M/BMI) completed the 1-year program. Similarly, Brandeis found the use of Medicare's traditional, exercise-based cardiac rehabilitation benefit to be extremely low. Only 12% of eligible Medicare beneficiaries use the benefit despite convincing evidence of its benefits in extending life and reducing re-hospitalization. While the evaluation's findings suggest that more intensive lifestyle modification programs are clinically effective, their additional costs and difficulties in enrollment reduce their advantage for the Medicare program compared to traditional cardiac rehabilitation. Nevertheless, in March 2006, Medicare included intensive cardiac rehabilitation programs, such as the Ornish and M/BMI programs, as acceptable programs for beneficiaries eligible for the cardiac rehabilitation benefit.

The reports are available here. For more information, please contact Armen Thoumaian at 410-786-6672 or armen.thoumaian@cms.hhs.gov.

Evaluation of Part D Payment Demonstration to Limit Annual Changes in Part D Premiums - Final Report

The findings for this report, which focused on partial low-income subsidy (LIS) and non-LIS enrollees, include:

- **Monthly premiums:** 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 Medicare Advantage Prescription Drug Program (MA-PD) enrollees in 2007.
- **Switching:** Beneficiaries rarely switched between plan types, but moved between benefit types (basic vs enhanced), especially among MA-PD enrollees. When faced with premium increases, the vast majority of non-LIS PDP beneficiaries still stayed in the same plan. It is estimated that about 130K beneficiaries would have switched to a lower cost plan without the demonstration.
- **Take up of Part D:** This was minimally affected. An estimated 4,500 fewer beneficiaries would have enrolled in Part D without the demonstration.

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

Evaluation of Part D Payment Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries (LIS) - Final Report

The findings for this report, which focused on LIS enrollees, include:

- **Regional benchmark premiums:** Higher regional benchmarks, combined with the de minimis policy, translated to greater numbers of zero-premium plans available in each region. This demonstration reduced the number of full LIS beneficiaries subject to re-assignment in 2007 from 4 million to 1 million LIS enrollees in 2007 and from near 2.9 million to 2.1 million LIS enrollees in 2008.
- **Re-assignment:** 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.
- **Effect of re-assignment:** Compared to re-assigned beneficiaries, beneficiaries who were 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.

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

Report to Congress: 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). The Part D program, launched on January 1, 2006, covered 25.2 million beneficiaries in 2007. Through CMS, the Part D program pays a direct subsidy to Part D plans, equal to a plan's risk-adjusted bid for a standardized benefit package minus the beneficiary's base premium for the standard package. Section 107 of the MMA mandates that the Secretary conduct a study on the "regional variations in prescription drug spending."

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.

Report to Congress: Information on the Competitive Acquisition Program

Section 303(d)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.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 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 to Congress 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 biologicals; and satisfaction among

participating physicians. This report is based on experience realized under the first six months of the program.

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 Quality

PACE enrollees were compared to participants in programs that similarly strive to maintain the frail elderly, who are nursing home-certifiable, in the community. These programs are the Medicaid Home and Community-Based Services (HCBS) section 1915 waiver programs. Where available, HCBS programs are considered a viable alternative to PACE, except that HCBS programs do not include institutional long-term care services. To compare outcomes of people enrolled in PACE and in the HCBS comparison group (located in states with PACE organizations), participants in each group were interviewed in two surveys in 2005 and 2006. Results of these surveys indicate that, compared with HCBS enrollees, PACE enrollees had better health management outcomes. They were more likely to have end-of-life documents in place, reported less pain that interfered with normal daily functioning, and were less likely to report unmet needs in getting around and dressing (two activities of daily living). PACE enrollees were more likely to have received hearing and vision screenings, a flu shot, and were more likely to have ever received a pneumococcal vaccination. They also reported higher levels of health status and fewer indicators of depression during the first survey, but PACE respondents were more likely to have exhibited certain behavioral problems. Most HCBS participants and PACE enrollees reported satisfaction with their quality of life and the quality of care they received over the study period. The financial incentives of a capitated payment system and the requirement to provide long term institutional care are consistent with the higher quality levels generally reported by PACE enrollees.

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.

The Physician Group Practice Demonstration Evaluation Report

This fourth and final statutorily mandated report assesses the impacts on expenditures, access, and quality using data from the 10 participating practices in the first two years (April 1, 2005 through March 31, 2007) of this five-year demonstration. The evaluation found that in the first two years of the demonstration, Medicare expenditure savings of $26,907,000 were achieved. Offsetting these savings were performance payments of $21,163,000, which were made to four Physician Group Practice (PGP) sites, and expenses of $3,484,000 that exceeded the target expenditures at two PGP sites. After these deductions, the net savings to the Medicare Trust Funds were $2,260,000.

Preliminary analyses could not detect if the savings at the four sites earning performance payments were prompted directly by the demonstration.

At the end of the second performance year, the groups demonstrated improvements in the quality of care that could be attributed to the demonstration. In addition, beneficiaries had greater access to care management programs and redesigned care processes that were established or extended by the participating sites under the demonstration.

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.

6. Current Demonstrations and Research Projects

Announcing the Results of Three Demonstrations and the Start of New Value-Based Purchasing Demonstrations

CMS announced new results from three different demonstrations. Results were announced for large physician practices, small and solo physician practices, and hospitals. CMS also announced the start of three additional value based purchasing demonstrations including the Nursing Home Value-Based Purchasing demonstration. The Nursing Home Value-Based Purchasing demonstration will reward facilities that improve or deliver quality care in four areas: nurse staffing, resident outcomes, avoidable hospitalizations, and reduction of the scope and severity of deficiency citations the home may have received during inspections.

To read more about these demonstrations, please view the press release here.

Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration

Secretary of Health and Human Services Kathleen Sebelius recently announced that Medicare, along with Medicaid, will participate in initiatives to test and support new models of primary care. The Multi-Payer Advanced Primary Care Practice Demonstration will be open to states that have implemented multi-payer programs to encourage the adoption of the "advanced primary care practice model," which is also referred to as the "medical home." This model involves several components that include:

- changes in methods of provider payment to enable physicians to spend more time with patients and better coordinate care with other providers,
- increased emphasis on disease prevention,
- and a more effective use of information and information technology to improve care.

State programs are also expected to include community support for small practices. Development of the demonstration is underway and states will be invited to apply in order to participate later this fall.

To read more about this demonstration, please view the press release here.

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

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