Below please find the Summer 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:

- New CMS Linked Data, the new Medicare & Medicaid Research Review, and the Medicare Current Beneficiary Survey
- New research reports by CMS staff
- Updates of 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. *CMS Data Linked to NCHS Surveys*

The National Center for Health Statistics (NCHS) is currently linking various NCHS surveys with Medicare enrollment and claims records. Medicare enrollment and claims data are available for those NCHS respondents who agreed to provide personal identification data to NCHS and for whom NCHS was able to match with Medicare administrative records. Linkage of the NCHS survey participants with the CMS Medicare data provides the opportunity to study changes in health status, health care utilization and expenditures in the elderly and disabled U.S. population.

CMS provided NCHS with Medicare benefit claims data for 1991 through 2000 for all successfully matched NCHS survey participants. NCHS is currently in the process of updating the CMS-NCHS linked data to include Medicare data through 2007 as well as Medicaid data. The linked CMS-NCHS files are restricted-use files that can be accessed through the NCHS Research Data Center (RDC). NCHS has created Feasibility Study Data files to assist researchers who are considering submitting an RDC application to analyze the linked CMS-NCHS data.

For more information, you may access the website here or contact Kimberly Lochner at 410-786-7706 or Kimberly.Lochner@cms.hhs.gov.

2. Call for Papers – Medicare & Medicaid Research Review (MMRR)

The Medicare & Medicaid Research Review (MMRR), CMS' peer reviewed research journal, is soliciting studies, policy analyses, and program evaluations that use rigorous, scientific research methods.

We are interested in papers addressing changes in coverage, quality, access, the organization and delivery of health services, payment for health services, and innovative methods.

Topics include, but are not limited to, the following illustrative examples:

- development, use, and effects of quality-based and bundled-service payment models;
- impact of Medicaid eligibility changes on the organization and delivery of care;
- descriptive analyses of longitudinal utilization and cost patterns among Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries;
- impact of changes to the private health care system on Medicare, Medicaid, and CHIP;
- impact of changes in cost sharing and coverage on care utilization patterns and outcomes;
- analyses of the types of health research questions amenable to quick study and implementation, and those questions that are not.

Although our scope is broad, submitted manuscripts should pertain at least indirectly to the Medicare, Medicaid or the Children's Health Insurance programs. Submitted manuscripts must report the results of original scholarship. Papers that are primarily editorial or opinion-based will not be considered. Papers with results that directly support actionable recommendations will receive priority for publication. Criteria for selection of manuscripts include (1) quality, rigor, and originality, (2) significance and usefulness for informing the future of Medicare, Medicaid & CHIP; and (3) clarity of writing and presentation.

All manuscripts must be submitted by email to MMRR-Editors@cms.hhs.gov and conform to the "Information to Authors and Electronic Submission Guidelines" available for download here. This is an ongoing call for papers with no submission deadline.

For more information, please contact David Bott, Ph.D., Editor-in-Chief, at (410) 786-0249 or MMRR-Editors@cms.hhs.gov.

3. Medicare Current Beneficiary Survey (2007 Cost and Use)

In October, 2010 the 2007 Cost and Use data file will become 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 "ever enrolled" population, including both those who entered Medicare and those who died during the year. The Cost and Use file is released annually and marks the sixteenth full year of collection. The file represents a combination of linked survey reported data from the MCBS, Medicare claims, and other data from the Centers for Medicare and Medicaid Services' administrative files. This comprehensive data set provides an accurate picture of all health services received (including non-Medicare covered), amounts paid, and sources of payment for Calendar Year 2007.

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

4. New Research Reports

Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare Final Report

This final report describes the methodology and findings utilized to assess the feasibility and advisability of expanding the coverage of chiropractic services under the Medicare program. The evaluation was conducted to determine whether 'eligible' beneficiaries who utilize the expanded chiropractic services within four demonstration treatment regions use relatively lower or higher amounts of services paid by the Medicare program versus beneficiaries with approved neuromusculoskeletal (NMS) diagnoses treated medically within the respective control regions. The evaluation determines the regional, overall, and service-specific costs for such expansion of chiropractic services under the Medicare program and ascertains the satisfaction, perceived functional status, and concerns of eligible beneficiaries receiving reimbursable chiropractic services in the treatment regions. This study verifies the quality of the expanded chiropractic care received, based upon outcomes that can be derived from claims data and concludes whether the demonstration achieved budget neutrality for the aggregate costs for beneficiaries with chiropractic-eligible NMS diagnoses, as well as the amount of any resultant savings or deficit to the Medicare program. Information in this report was included in the January 2010 Report to Congress.

The electronic version of the report is available here.

For more information, please contact Carol Magee at 410-786-6611 or Carol.Magee@cms.hhs.gov.

Evaluation of the Low Vision Rehabilitation Demonstration Provider Case Studies Final Report

The purpose of this report is to present the results of Brandeis University's evaluation of the implementation by low vision providers of the Low Vision Rehabilitation Demonstration (LVRD). The report includes case studies of five major organizations and four independent providers who either participated or considered participating in the LVRD. This list includes Lighthouse International, New York City, NY; Metrolina Association for the Blind, Charlotte, NC; New Hampshire Association for the Blind, Concord, NH; Center for the Visually Impaired, Atlanta, GA; and Community Services for the Blind and Partially Sighted, Seattle, WA. The only providers that were able to successfully participate in the Demonstration were large, non-profit organizations for the blind.

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.

Evaluation of the Low Vision Rehabilitation Demonstration Claims Analysis Final Report

The intervention that was implemented by the Low Vision Rehabilitation (LVR) Demonstration was a change in Medicare coverage. Specifically, during the demonstration period, Medicare covers the services of LVR therapists regardless of place of service when they are prescribed by a qualified provider (in this case, an ophthalmologist, optometrist, or other physician) for beneficiaries enrolled in Medicare Part B who reside in particular demonstration areas. The purpose of this report is to use claims only information to describe low-vision rehabilitation users, determine population-based rates of use, and any shifts in the amount, type, providers or place of service associated with the demonstration are then presented.

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.

Evaluation of the Medicare Low Vision Rehabilitation Demonstration Beneficiary Case Study

The purpose of this report is to present the results of Brandeis University's evaluation of beneficiaries' experiences of the Low Vision Rehabilitation Demonstration (LVRD). The case study collected information from nine beneficiaries in the Atlanta area who had received low vision (LV) services from the Center for Visual Impairment (CVI), one of the organizations participating in the demonstration. Open-ended interview questions used focused on beneficiary characteristics, the process of referral and care, the LV rehabilitation services they received, their experiences with these services and providers, and the effectiveness of the services.

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.

Low-Income Medicare Beneficiaries and their Experiences with the Part D Prescription Drug Benefit

This study seeks to understand how much beneficiaries knew about the Medicare prescription drug benefit (Part D) and low-income subsidy (LIS) programs and what their experiences were with the programs in 2006. Part D enrollees who automatically qualified for the LIS were less likely to report awareness that they could switch among different plans, had lower knowledge scores, and were more likely to have medications not covered by the plan compared to beneficiaries who applied for the LIS and others who enrolled in Part D but did not receive the LIS. Communication efforts to the LIS population, particularly for beneficiaries deemed automatically eligible for the LIS, need to continually make them aware of their benefits and protections in Part D. The paper is included in the current issue of the journal *Inquiry (Vol. 47, Issue 2)*, which is available online.

For more information or to obtain access to the report, please contact Noemi Rudolph at (410) 786-6662 or Noemi.Rudolph@cms.hhs.gov and Melissa Montgomery at (410) 786-7596 or Melissa.Montgomery@cms.hhs.gov.

Part D Payment Demonstration Evaluation Final Report

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 will present the overall findings from Medicare Part D Reinsurance Demonstration Evaluation that examined the impact of the demonstration on benefit structure, plan organization and behavior, beneficiary satisfaction and Part D enrollment and expenditures and utilization.

The electronic version of the report is available here.

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

Simulating the Impact of Transitioning Medicare Drugs from B-to-D and from D-to-B

The Secretary's 2005 Report to Congress on Transitioning Medicare Part B Covered Drugs to Part D suggested that there were a limited number of categories of drugs where

it might be beneficial to consolidate coverage under one program. This subsequent report presents findings of a study aimed at understanding the financial and programmatic impacts of consolidating certain categories of similar drugs under one program. This report focuses on four categories of drugs that may have the greatest potential for program consolidation: 1) anti-cancer drugs, 2) anti-emetic drugs, 3) vaccines, and 4) inhalants. A baseline simulation approach is initially being used followed by additional simulations to account for behavioral effects of beneficiaries and prescribers if these medications were to be consolidated under one programs.

For more information or to obtain a copy of the report, please contact Steve Blackwell at 410-786-6852 or Steve.Blackwell@cms.hhs.gov.

State Government Tracking of Hospital-Acquired Conditions

This report provides a comprehensive review on the status of State government tracking of Hospital-Acquired Conditions (HACs). As of March 2010, 26 States and the District of Columbia have enacted legislation to establish adverse event reporting systems. There are no federal standards for State reporting systems and no uniform list of reportable events or HACs. Fourteen States use the National Quality Forum's list of 28 serious reportable events, and twelve States have identified their own sets of reportable events. States vary widely as to the total number of HACs tracked through a State-based reporting system. The States use data in similar ways to improve patient safety and employ quality improvement programs, and most of the States provide aggregated public reports. In the absence of a nationally based mandated reporting system, States serve a significant role collecting and reporting HAC data.

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.

Surmounting the Challenges of Measuring and Improving Quality in Ambulatory Care

The paper, written for the Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse website, highlights the fact that the large number of physician practices with few physicians, multiple payers, and a lack of interconnectivity via electronic medical records has created statistical and logistical challenges with measuring and improving the quality of ambulatory care.

The electronic version of the report is available here.

For more information, please contact David Nyweide at 410-786-0699 or David.Nyweide@cms.hhs.gov.

5. Current Demonstrations and Research Projects

Medicare Imaging Demonstration (MID)

The Centers for Medicare & Medicaid Services (CMS) solicited proposals for participation in the Medicare Imaging Demonstration (MID). Applications were due to CMS by September 21, 2010. The MID was authorized by section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 and will test whether the use of decision support systems (DSSs) can improve quality of care and reduce unnecessary radiation exposure and utilization by promoting appropriate ordering of advanced imaging services.

The two-year demonstration will assess the impact that DSSs used by physician practices have on the appropriateness and utilization of advanced medical imaging services ordered for the Medicare fee-for-service population. A DSS provides immediate feedback based on current medical specialty guidelines to the physician on the appropriateness of the test ordered for the patient. In addition, the demonstration will focus on magnetic resonance imaging, computed tomography, and nuclear medicine advanced imaging diagnostic services. All current Medicare coverage and payment policies are unaffected under this demonstration. Prior authorization processes, which can be used to deny coverage for tests, are not part of the demonstration.

CMS will use "conveners" to reach eligible physicians interested in participating in the demonstration. Conveners will be responsible for recruiting physician practices, deploying a DSS that incorporates medical specialty society guidelines for the selected procedures, ensuring the DSS remains current with those guidelines, collecting and transmitting data, and distributing payments to practices for reporting data. Conveners and physician practices will be paid for reporting complete data necessary to determine the appropriateness of the test.

Eleven advanced imaging procedures -- Spect MPI, MRI lumbar spine, CT lumbar spine, MRI brain, CT brain, CT sinus, CT thorax, CT abdomen, CT pelvis, MRI Knee, and MRI shoulder -- will be included in the demonstration. The 11 tests were selected based on high expenditures and utilization in the Medicare fee-for-service population and the availability of relevant medical specialty appropriateness guidelines. The law requires that the appropriateness criteria used in the demonstration be based on those developed or endorsed by medical specialty societies. CMS worked with medical specialty societies and other stakeholders, including the AQA Alliance, to solicit their input and information on available appropriateness criteria.

For more information about the demonstration, please email questions to ImagingDemo135b@cms.hhs.gov or visit the demonstration web site here.

Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration

In June, CMS announced the opening of the solicitation process for states to submit applications for the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration. Under this 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.

Applications were submitted on August 17th and are currently under review. A decision on the selected sites is expected to be made later this fall.

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

Rural Community Hospital Demonstration Program

Section 10313 of the Patient Protection and Affordable Care Act of 2010 mandates an extension of the Rural Community Hospital Demonstration Program for an additional 5 years. The law allows additional hospitals to participate in the demonstration program. Since 10 hospitals are currently participating in the program, CMS is conducting a new solicitation that will allow up to 20 new hospitals to participate in the demonstration for a period of 5 years. Congress included this provision in the law in response to the financial concerns of small, rural hospitals that are too large to qualify as Critical Access Hospitals (CAH). The demonstration is designed to test the feasibility and advisability of reasonable cost reimbursement for inpatient services to small rural hospitals. The demonstration is aimed at increasing the capability of the selected rural hospitals to meet the needs of their service areas.

For more information about the demonstration, please visit the demonstration web site here.

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

Click **here** to subscribe/unsubscribe to this listserv.