Below please find the Winter 2011 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:

- The 2011 Active Projects Report
- $100 Million in Affordable Care Act Grants to Prevent Disease
- New research reports by CMS staff

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 2011 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. Comparative Effectiveness Research Public Use Data Pilot Program (ORDI)

CMS received ARRA funding to increase its efforts to provide access to public use claims files, and included claims-based public use files (PUFs) as high value data sets that would be released on data.gov as part of the agency's Open Government plan. After extensive analysis, discussion, testing, and consultation with national experts, we produced an initial claims-based PUF that is analytically useful and has been certified as meeting the HIPAA Statistical Standard for a de-identified data set. This initial file, the CMS 2008 BSA Inpatient Claims PUF, was released publicly on February 12, 2011.

Other similar files for Part D events, Hospice Claims and DME Claims are planned for release in April 2011.

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

3. Availability of the National Cancer Institute (NCI) SEER-MHOS Linked Data Set

CMS is pleased to announce the availability of the Surveillance, Epidemiology, and End Results (SEER) and the Medicare Health Outcomes Survey (MHOS) linked data sets. The linked data set is a surveillance data set that links data on cancer patients to patient-reported outcome measures and provides researchers with the potential to investigate the health status and health related quality of life of older adults enrolled in Medicare Advantage Organizations with and without a cancer diagnosis.

The SEER-MHOS linked data sets available now include data collected during the years of 1998-2003. The HOS data are from baseline and follow up surveys for *Cohorts 1-4* collected during the same time-period. For researchers who are interested in using this linked data in their investigations, please go to the following website for information:

http://outcomes.cancer.gov/surveys/seer-mhos/

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

4. HHS Announces $100 Million in Affordable Care Act Grants to Prevent Disease

As part of the nation's efforts to prevent an increase in the number of people with chronic health conditions, the Department of Health and Human Services (HHS) announced a new, $100 million program allowing states to offer incentives to Medicaid enrollees who adopt healthy behaviors such as quitting smoking or losing weight.

Under the Act, states may apply to the Centers for Medicare & Medicaid Services (CMS) for grants to fund programs that demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. One way to encourage difficult changes in life habits such as overeating or smoking, research has shown, is to offer economic incentives to those who reach stated goals. With that in mind, CMS will encourage states to adopt such strategies as rewarding Medicaid enrollees who meet goals established for them such as weight loss, smoking cessation or diabetes prevention or control. Rewards could range from direct cash incentives, gift cards to grocery stores or other retailers,

reduced Medicaid program fees (if any apply) or offering services not normally available through Medicaid.

The program focuses on those behaviors that can cause some of the most critical chronic conditions that together affect millions of Americans. Research in the field, largely based on commercial insurance program experience, has shown that financial incentives can be effective in the short run for simple preventive care and distinct behavioral goals, but this demonstration will attempt to identify the most effective strategies for major, long-term changes in unhealthy habits.

States can get more information about the incentive grants at http://www.cms.gov/MIPCD/.

5. New Research Reports

ARRA-CER Medicaid Analytic eXtract Production, Development, and Data Quality (MAX-PDQ): Medicaid Database Sample Feasibility Study Final Report

A Medicaid Sample Database was considered to make it easier for current MAX researchers to design and conduct studies. The Medicaid Sample Database called "Mini-MAX" enables researchers to conduct Comparative Effectiveness Research (CER) and other types of analysis on a smaller database at a far lower cost. It will also allow researchers and analysts, who do not have mainframe access or otherwise unable to process full MAX data on their PC, to access a sample of MAX data on a statewide basis. The report focuses on various methodological design issues and options that were addressed by a Technical Expert Panel (TEP). The report presents findings and recommendations by the TEP to design a "Mini-MAX" sample and provide a set of specifications on a set of "skinny" files that are based on a component of files in the full MAX dataset.

The electronic version of this report can be found here.

For more information, please contact William Clark at 410-786-1484 or william.clark@cms.hhs.gov.

Determining Medical Necessity and Appropriateness of Care at Medicare Long-Term Care Hospitals: Report to Congress

This Report to Congress is prepared in response to section 114 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173) which states that the Secretary of Health and Human Services shall conduct a study on the establishment of national long-term

care hospital (LTCH) facility and patient criteria for determining medical necessity, appropriateness of admission, continued stay and discharge from long-term care hospitals. The Centers for Medicare & Medicaid Services (CMS) contracted with Kennell and Associates with a subcontract to Research Triangle International (RTI) to conduct this study which provides a review of past studies by MedPAC, the LTCH industry and RTI (under contract to CMS) examining patient and facility characteristics of LTCHs and past examinations of LTCH payment adequacy and patient appropriateness. This is followed by an examination of the clinical characteristics of the LTCH population focusing on defining medical complexity, identifying critically complex patients, predicting outcomes for these patients using severity scoring systems, and evaluating quality of care for these patients. The final chapter presents an agenda for research to be completed to define a critically complex patient population. This study is attached to this Report to Congress as Appendix I.

For more information, please contact William Buczko at 410-786-6593 or william.buczko@cms.hhs.gov.

Evaluation of the Electronic Health Records (EHR) Demonstration: Implementation Report

The first of two rounds of site visits were conducted in spring 2010 to four treatment and two control practices in each site for total of 16 treatment and eight control group practices. Toward the end of the first demonstration year, 12 of the 16 treatment group practices were using an EHR and seven of them had an EHR in place for more than a year. Five of the eight visited control group practices reported having an EHR, with three of them for more than a year. Treatment and control practices that did not have an EHR reported that cost in terms of money and labor is a barrier to implementing an EHR. Barriers to implementation and use reported by practices in both study groups that have EHRs include time and labor to implement the system, complexity of the electronic systems, lack of interoperability with other systems, and insufficient technical support. Factors influencing acquiring and implementing EHRs among practices in both study groups included the national focus on adoption, strong advisory groups or resources (steering committees at practice or group level), and strong training in terms of high quality vendor support.

The electronic version of this report can be found here.

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

Evaluation of ESRD Disease Management Demonstration: Final Report

This report presents the evaluation findings of the first three years of the End-Stage Renal Disease Management Demonstration (DMD). The DMD included Medicare beneficiaries

with ESRD enrolled into fully capitated ESRD disease management organizations (DMOs). The evaluation focused on four key questions:

1) Does disease management (DM) improve survival, improve transplantation rates and decrease all-cause and cardiovascular (CV) hospitalizations?
2) How does DM affect patient satisfaction, quality of life, and disenrollment?
3) How does DM affect provider satisfaction?
4) What is the effect of DM on costs?
5) What are the effects of DMO-specific interventions designed to improve selected processes of care?

Improved survival and reduced all-cause and cardiovascular hospitalizations at one and two years were noted for one of the DMOs. Although one DMO had higher rates of transplant wait-listing compared to FFS, transplantation rates were either lower or no different that rates in FFS at one and two years. Demonstration enrollees expressed satisfaction with their care. Quality of life scores did not improve at one year from baseline. The most common reasons for disenrollment included issues with misunderstandings about the DMOs and cost/billing issues. Providers in the demonstration indicated they thought the DMOs had positively influenced the management of enrollees' comorbid conditions and expressed overall satisfaction with the DMOs. As expected, similar to reports of higher costs to Medicare for Medicare Advantage enrollees, capitated payments to the DMOs in this demonstration cost Medicare 13.4% more than the estimated FFS cost if demonstration enrollees had remained in FFS. Improvements were noted for some DMO-specific interventions in the areas of preventive care immunizations, diabetic retinal exams, HbA1c testing and the use of oral nutritional supplements associated with reduced mortality among targeted patients.

The electronic version of this report can be found here.

For more information, please contact Diane Frankenfield at 410-786-7293 or diane.frankenfield@cms.hhs.gov.

Evaluation of the Medical Home Demonstration: Assessment of PCMH Instruments

RTI and Urban Institute (UI) prepared a briefing paper that describes and compares the various instruments available for assessing patient-centered medical home (PCMH) capabilities and assesses the strengths and limitations of each instrument. To assist with this analysis, UI conducted telephone interviews with recognized leaders in this area to get their views on the relative merits of different instruments and with individuals from State agencies and health plans implementing PCMH projects to understand why they selected the PCMH assessment instrument they chose to use.

For more information, please contact Suzanne Goodwin at 410-786-0226 or suzanne.goodwin@cms.hhs.gov.

Evaluation of the Medicare Care Management Performance Demonstration: Final Site Visit Report

In spring 2010, a second round of site visits were conducted in 29 of the 32 practices that were visited in 2008 (three had withdrawn from the demonstration). The site visits showed that some practices can and do respond operationally to incentives. Among those with an EHR, there were modest increases in use of EHRs and other health IT for care management. Eight of the 22 with EHRs reported a more effective use of certain features of their EHRs, e.g, reminders and test ordering. One of the seven that did not have an EHR at the start of the demonstration began using one by the end of the demonstration. Factors influencing adoption and improved use of health IT include availability of financial and technical support, presence of a champion in the practice who strongly encouraged use of health IT, and more experience with EHRs and other health IT over time. Initial and ongoing maintenance, cost, and lack of technical support remain barriers to the implementation and use of EHRs. Many of the visited sites expressed dissatisfaction with their EHR products, particularly those with over-sensitive alerts, reminders, and need for streamlined templates for chronically ill patients with multiple conditions.

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

Evaluation of the Rural Hospice Demonstration: Report to Congress

Section 409 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required the implementation of the demonstration, which began October 1, 2005, and ended on September 30, 2010. The demonstration provided that Medicare beneficiaries in rural areas who lacked an appropriate caregiver could receive care in a facility of 20 or fewer beds that offers, within its walls, the full range of services provided by hospice programs. The demonstration waived the requirement that hospice programs provide care in the patient's home and the aggregate percentage limit on the number of days of inpatient services that each hospice can provide. The legislation also mandated that the Secretary report to Congress upon completion of the demonstration on recommendations regarding extension of the demonstration to hospice programs serving rural areas. Two hospices participated in the demonstration: Sanctuary Hospice House located in Tupelo, Mississippi and Haven House Hospice in Florida. Sanctuary Hospice House requested both of the exceptions provided for in the legislation; therefore, they treated all patients in their facility. Haven Hospice did not request either exception. Neither of the two statutory hospice requirements waived by section 409 of the MMA is needed for the future operations of either of these hospices. Both hospice programs were able to implement and utilize quality assessment and performance improvement programs (QAPI). Findings from this demonstration cannot necessarily be generalized to other hospice programs serving rural areas.

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

Evaluation of the Rural PACE Provider Grant Program: Report to Congress

This Report to Congress (RTC) presented findings prepared in response to Section 5302 of the Deficit Reduction Act (DRA). The DRA authorized the rural PACE provider grant program to expand the Program for the All-inclusive Care for the Elderly (PACE) to rural areas of the United States. PACE is an innovative model of care and an established Medicare benefit and Medicaid State Plan option that aims to help the frail elderly population continue living in the community. This report presents qualitative findings based on site visits, guided conversations, document review, and administrative data. Sites found the CMS grant to be indispensible to their successful launch. Two central and related challenges were that participants did not want to give up their primary care physician and physicians were wary of losing their patient population to PACE, both of which were ameliorated by the use of the Community-based Primary Care Physician (CBPCP) waiver at most of the 14 awarded sites. Over the course of the second year of operation, two sites faced possible termination. The first site, *Vermont PACE*, was made whole financially by a new parent organization. The second site, *Maui PACE*, will terminate its program August 31, 2010. Rural PACE sites that were able to overcome the challenges of applying the innovative PACE model of care to the rural setting have been able to experience its numerous benefits. The most successful sites are those with established, experienced and financially sound sponsoring organizations. Those sites that have formal referral-based relationships with their parent organizations are also better able to thrive (e.g., Area Agencies on Aging). Finally, rural PACE sites have been better able to survive, especially during periods of very low enrollment, when they are connected operationally to a non-rural PACE component. This report finds overall favorable experience by the rural PACE pilot sites, as well as their beneficiaries and communities in the early phases of implementation.

The electronic version of this report can be found here.

For more information, please contact William Clark at 410-786-1484 or william.clark@cms.hhs.gov

Hospital Acquired Conditions-Present on Admission (HAC-POA) Program: Evidence-Based Guidelines Report

This semiannual report identifies and characterizes the contemporary evidence-based guidelines available for each of the selected and previously-considered HACs that provide recommendations for the prevention of the corresponding condition in the acute hospital setting. Guidelines were primarily identified using the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearing House (NGCH) and the CDC, along with relevant professional societies. Guidelines published in the United

States were used, if available. In the absence of U.S. guidelines for a specific condition, international guidelines were included.

The electronic version of this report can be found here.

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

Medicare Part D Program Evaluation - Analysis of Impact of Medicare Part D on the FFS Program and Issues Related to Medication Adherence for Six Chronic Conditions - 2007: Final Report

This report examines the impact of Medicare Part D on beneficiaries with chronic conditions that are considered to be sensitive to drug therapies:

- Chronic obstructive pulmonary disease (COPD),
- Congestive heart failure (CHF),
- Diabetes with complications,
- Dementia,
- Major depression, and
- Rheumatoid arthritis

The analysis focused on answering 4 key research questions:

1) What are Part D enrollment patterns for beneficiaries with specific chronic conditions?
2) What is the impact of Part D on patient adherence to medication therapy?
3) What is the impact of Part D on health outcomes and health care utilization and costs for beneficiaries with chronic conditions?
4) What is the relationship between differences in patient adherence and differences in health outcomes and health care utilization and cost?

The electronic version of this report can be found here.

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

Study of Urban Medicare-Dependent Hospitals: Report to Congress

Section 3142 of the Affordable Care Act mandated a study on the need for an additional payment for urban Medicare-dependent hospitals (UMDHs). UMDHs are defined as hospitals that do not receive any additional payments or adjustments under the Medicare prospective payment system, and for which more than 60 percent of their inpatient days or discharges were attributable to Medicare Part A during two of their three most recent

cost reporting periods. Section 3142 requires an analysis of the Medicare inpatient margins of UMDHs as compared to hospitals receiving one or more additional payments or adjustments. The analysis revealed low average Medicare inpatient operating margins for UMDHs (-12.0%) relative to hospitals receiving additional payments or adjustments (-1.2%). However, the pattern of low Medicare inpatient operating margins was not limited to hospitals that are Medicare-dependent, and average Medicare inpatient operating margins were, in fact, lower for hospitals that were not Medicare dependent and did not receive additional payments or adjustments (-23.4%). The report recommends that a review be conducted to evaluate the appropriateness of current Medicare payment policies under the prospective payment system, especially related to hospitals that do not currently receive additional payments or adjustments.

The electronic version of this report can be found here.

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