Below please find the Winter 2010 edition of *News from ORDI*, a quarterly publication summarizing recent work undertaken in ORDI and the results we've produced. Highlights from this quarter's *News* include:

- Release of the 2009 *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*.
- Release of the 2009 *Data Compendium*.
- 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: Medicaid & Medicare Statistical Supplement*

The 2009 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 2009 edition, as well as earlier editions, is available **here**.

For more information, please contact Debbie Kidd at 410-786-7204 or Deborah.Kidd@cms.hhs.gov.

2. *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 or Maria.Diacogiannis@cms.hhs.gov.

3. Prevention Data on CMS Website

CMS has posted information on beneficiary use of Medicare preventive benefits at the national, state, and county level on the CMS website.

Prevention is one important element in an overall federal effort to promote value in health care for people with Medicare. Despite the fact that Medicare covers a comprehensive package of preventive benefits, there is a prevention gap between the available benefits and their utilization. Fewer than one in 10 Medicare beneficiaries receives all recommended Medicare screenings and immunizations.

Researchers, health professionals, and others interested in learning about the use of preventive services can view information on the use of Medicare preventive benefits by going here and clicking on the links on the left side of the screen for "Medicare Claims Data" and "Self-Reported Data."

Data from Medicare claims for calendar years 2005-2008 are featured in an interactive database that allows users to examine the use of many preventive services at the national, state, and county level, and by demographic groups at the national and state level. Information on the use of preventive services from various surveys is also available for downloading.

It is important to note that there are limitations in the accuracy of both Medicare claims and self-reported data, in that claims tend to under-report use of services, while self-reported data tends to over-report use. However, these data sources can be helpful in examining trends in the use of services over time. A "Data User's Guide" is available for downloading and explains some of these limitations. CMS plans to make future refinements to include information on the use of other Medicare preventive benefits.

The prevention interactive database is located **here**. Questions, comments, and suggestions regarding information on the use of preventive services should be sent to prevention@cms.hhs.gov.

4. Published Articles

Long-term Trends in Medicare Payments in the Last Year of Life

Authors: Gerald F. Riley M.S.P.H., James D. Lubitz M.P.H.
Publication: *Health Services Research.* Published online in advance of print on February 9, 2010.

Abstract

Objective: To update research on Medicare payments in the last year of life
Data Source: Continuous Medicare History Sample, containing annual summaries of claims data on a 5 percent sample from 1978 to 2006.
Study Design: Analyses were based on elderly beneficiaries in fee for service. For each year, Medicare payments were assigned either to decedents (persons in their last year) or survivors (all others).
Results: The share of Medicare payments going to persons in their last year of life declined slightly from 28.3 percent in 1978 to 25.1 percent in 2006. After adjustment for age, sex, and death rates, there was no significant trend.
Conclusions: Despite changes in the delivery of medical care over the last generation, the share of Medicare expenditures going to beneficiaries in their last year has not changed substantially.

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

5. New Research Reports

Evaluation of Care and Disease Management under Medicare Advantage: Final Report

The purpose of the project was to conduct a qualitative assessment of care and disease management programs available through MA plans. The evaluation was conducted by L&M Policy Research, and consisted of a literature review, expert interviews, a plan survey, and 6 case studies. The evaluation centered on four key topics:

- types of programs and models
- identification of target populations
- role of health plans
- evidence of effectiveness

On average, C/DM programs offered through MA plans appear to be in the early stages of development. There is certainly strong evidence that managed care organizations are invested in C/DM and believe that these programs are important offerings to members. They are, however, still in the process of crafting appropriate and efficient information systems to support C/DM care teams and integrate data sources across different platforms (e.g. lab data, pharmacy data, administrative data) to facilitate effective monitoring and evaluation efforts.

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

Evaluation of the Demonstration of Coverage of Chiropractic Services under Medicare

Mandated by the MMA Act of 2003, the demonstration examined the effects of expanding Medicare Part B coverage and eligibility for chiropractic services for neuromusculoskeletal (NMS) diagnoses in four areas (Maine; New Mexico; 26 Illinois Counties + Scott County, Iowa; 17 Virginia Counties) including two rural and two urban regions. Chiropractor participation was voluntary. All chiropractors in these areas could participate, thus any Part B patients of participating chiropractors, were eligible. Congress mandated budget neutrality, with the stipulation that CMS must recoup any significant excess demonstration costs from the future Part B payment schedule for chiropractors. This evaluation, conducted for CMS by Brandeis University, covered:

- implementation issues,
- beneficiary satisfaction survey,
- utilization, and
- budget neutrality

Implementation was slow during year one due to difficulties implementing its complex billing system and to minimal publicity. Overall, only 40% of eligible chiropractors participated. Surveyed beneficiaries reported good relief of symptoms and high degrees of satisfaction with the chiropractic care received. Among users of expanded services, chiropractic visits increased by 60% and Medicare Part B expenditures increased by $34.8 million. Budget neutrality was not achieved and reimbursements across all Medicare services (Parts A, B, etc.) increased by $114 million for all beneficiaries with NMS diagnoses, or by $50 million among the subset of the NMS-diagnosed who actually used any chiropractic services. The Final Report to Congress was sent to Congress in January 2010. A separate, more-detailed report on the Budget Neutrality can be found on the web **here**.

The electronic version of the report is available **here**.

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

Evaluation of Medical Savings Account (MSA) Plans Under the Medicare Program: Cross-Cutting Findings Reports

The purpose of this study was to conduct a qualitative and quantitative assessment of MSA plans. The evaluation centered on four key topics:

- Describe the early patterns of enrollment into MSA plans;
- Examine the early stages of the development of the MSA market;
- Document the potential for risk selection; and
- Explore the impact of MSA plans on Medicare program spending

This report was designed to summarize and tie together earlier reports based on case studies, focus groups, and secondary data analysis. The research team identified 2,708 Medicare beneficiaries enrolled in an MSA plan in 2007, the majority of whom came from Medicare fee-for-service (FFS) and, more specifically, MA plans. Six states accounted for about 75 percent of MSA enrollment in 2007 and enrollees were more likely to be male, ages 65 to 74 and white or black than non-MSA enrollees. Furthermore, MSA enrollees tended to be healthier, have fewer medical conditions and have less Medicare spending. The research team used multinomial logistic regression models (MLMs) to determine whether health status exerted an independent effect on a beneficiary's decision to enroll in an MSA plan and found strong evidence that beneficiaries who enrolled into an MSA plan in 2007 were healthier than the general MA and FFS populations after controlling for age, race and dual eligibility.
In general, the research team concluded that, due to the small number of plans available and the lack of take-up by beneficiaries, many Medicare beneficiaries were not exposed to this new type of plan. As beneficiaries have a number of options for MA and Part D drug plans, the MSA option is just one choice and is, thus, not likely to capture much attention. Enrollment levels were only high in areas where brokers specifically marketed these plans to beneficiaries; in all other regions, those enrolling were most likely individuals who had prior knowledge or experience with such options. The research team determined further barriers to MSA enrollment, including: prorating the deductible, short selling season, lack of coverage for preventive care, client disbelief in receiving deposit and lack of prescription drug coverage. Still, focus group participants enrolled in MSA plans generally rated their plan positively.

For more information, please contact Melissa Montgomery at 410-786-7596 or Melissa.Montgomery@cms.hhs.gov.

Evaluation of Medical Savings Account (MSA) Plans Under the Medicare Program: Secondary Data Analysis Report

This report is part of a larger study assessing MSA plans. The Secondary Data Analysis Report examined Medicare administrative data for 2007 to explore issues related to selection bias and impact of MSA plans on Medicare spending and to profile the characteristics of MSA enrollees. Enrollees in MSA plans were compared to comparison groups of MA and fee-for-service (FFS) enrollees not enrolled in an MSA plan. The study found some evidence of selection bias. MSA enrollees were healthier than non-MSA enrollees based on HCC risk scores. However, the number of enrollees in MSA plans in 2007 was small. The study found that multiple factors outside of beneficiary health status and demographics influence plan choice decisions in the case of MSA enrollment. Plans with effective advertising campaigns and beneficiaries with family

member in private medical savings accounts have an important effect on MSA enrollment decisions.
Overall, the study found that MSA plans increased monthly Medicare spending at $129 per member, or approximately $1,500 per year. Three important limitations are worth noting. First, the study used national estimates of MA plan rebates instead of plan-specific rebate information. Second, the study is based on 2007 data and on a small number of MSA enrollees. Third, the study did not explore how MSA plans affect beneficiary out-of-pocket expenses.

For more information, please contact Melissa Montgomery at 410-786-7596 or Melissa.Montgomery@cms.hhs.gov.

Evaluation of the Second Phase of the Oncology Demonstration

Medicare Oncology Demonstration Program entitled, "Improved Quality of Care for Cancer Patients Through More Effective Payments And Evidence-Based Care", paid oncologists to capture information relevant to care provided to cancer patients, including their treatment and staging and the range of services they received from their providers based on evidence-based best practices.
This report describes how physicians adapted their practices to the oncology demonstration. In addition, the report describes the impact of using evidence-based clinical guidelines to deliver care, and lessons learned for future demonstrations involving specialist physicians. The report findings are based on primary and secondary data from participating oncologists and hematologists and information collected from Medicare claims.

Report findings include:

- physician office administrative staff performed a significant role in making decisions to participate in and implement the demonstration;
- demonstration-reported G-code data, when linked to Medicare claims data, may not accurately reflect the expected patterns of cancer care based on clinical guidelines; and
- expenditures for the oncology demonstration amounted to $66 million including beneficiary liabilities of approximately $13 million

Total Medicare expenditures for the 13 cancers included in the oncology demonstration were $4.7 billion in 2006.

The electronic version of the report is available **here**.

For more information, contact Pauline Karikari-Martin at 410-786-1040 or pauline.karikarimartin@cms.hhs.gov.

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

The Medicare Part D benefit extended drug coverage to millions of beneficiaries. The purpose of this research was to produce descriptive statistics that relate Part D enrollment to beneficiary characteristics and to estimate the impact of Part D enrollment on Part A and Part B utilization and expenditures. The evaluation was conducted by Research Triangle Institute (RTI) was based on analysis of Medicare data. The results of this research indicate that a little under half (45.7%) of FFS beneficiaries elected a Part D plan. There were substantively small but persistent indications that some older Medicare beneficiaries and beneficiaries diagnosed in prior years with costly chronic diseases were more likely to enroll in a Part D plan. RTI conducted analyses to determine whether we could observe any major shifts in Medicare FFS spending and utilization after the implementation of Part D. The analyses found little evidence that implementation of Part D had an impact on Medicare spending and utilization. Taken together, the results seem to suggest that the impacts of Part D on Medicare FFS spending and utilization in the first year of the program (2006 data only) may not manifest in the aggregate, among the beneficiary population as a whole and cause overall shifts in spending and utilization patterns. It seems more likely that impacts will be found among specific subpopulations and for targeted conditions. The next phase of the study will focus on the impact of Part D on beneficiaries with chronic conditions and will examine beneficiary characteristics, adherence to medication therapy, utilization, costs and outcomes.

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

Medication Use and Adherence among Medicare Beneficiaries with Diabetes and Selected Co morbidities Enrolled in Stand-Alone Part D Prescription Drug Plans

This report describes drug use and adherence with selected medications commonly prescribed to Medicare beneficiaries with diabetes. The study sample comprised 151,460 beneficiaries enrolled full year in Part D Prescription Drug Plans (PDPs) in 2006. The report evaluated medications in three classes: oral and injected antidiabetic drugs, renin-angiotensin-aidosterone system inhibiters (RAASIs) a class comprising ACE-inhibitors and angiotensin II receptor blockers (ARBs), and antihyperlipidemics (AHLDs) including statins and other lipid lowering agents. The outcome measures were any use of drugs within each class, duration of therapy, and medication possession ratios.
To examine whether the generosity of the Part D benefit influenced medication utilization patterns, the authors computed drug adherence rates for subsamples with and without Part D low income subsidies (LIS). To test whether there was a correlation between drug utilization and illness burden, the authors examined medication adherence for subjects with concurrent COPD and/or major depression as well as by quintile of cumulative Medicare expenditures in 2006.

The study major findings were:

- low overall utilization rates for the evaluated medications,
- strong negative association between illness burden and medication adherence,
- lower drug prevalence rates among LIS enrollees, and
- significant disparities in medication adherence between whites, blacks, and Hispanics

The electronic version of the report is available **here**.

For more information, contact Pauline Karikari-Martin at 410-786-1040 or pauline.karikarimartin@cms.hhs.gov.

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

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

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

CMS also substantially increased the inhalation drug dispensing fees paid to pharmacy-suppliers in 2004. Using Medicare claims data from 2000-2007, this study assessed the impact of the changes in payments for Part B covered drugs on beneficiaries, providers, and the distribution and delivery system for the drugs. The findings were generally encouraging for Medicare's change to an ASP-based payment system for Part B–covered drugs. The payment reforms appear to have controlled Medicare expenditures for Part B drugs and to have reduced beneficiaries' out-of-pocket liabilities for these drugs. Certain physician specialties saw reductions in their Medicare revenues, and users of specific types of drugs experienced modest shifts in where they received their drugs, but there were no large-scale or broad-based changes in sites of drug administration.

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

6. Current Demonstrations and Research Projects

Medicare Health Care Quality (MHCQ) Demonstration Programs – Two Projects Start in Indiana and North Carolina

The health care system's inability to deliver consistent, high quality health care has been the focus of political and scholarly debate for over a decade and, despite several

influential works offering fundamental strategies for improving the quality and efficiency of care provided, there has been both sparse and limited empirical evidence showing what works and what doesn't. With this in mind, Congress directed the Secretary of Health and Human Services to conduct a 5-year demonstration entitled the Medicare Health Care Quality (MHCQ) Demonstration.

Projects in Indiana and North Carolina will provide the Centers for Medicare and Medicaid Services (CMS) the opportunity to test whether or not two unique approaches to changing Medicare's traditional delivery and financing systems can lead to improved quality of care in Medicare patients. This demonstration is specifically designed to promote quality improvements and reductions in Medicare spending by allowing demonstration sites to share in a portion of Medicare savings, once certain quality and cost results have been achieved.

The first project to be implemented, which started in July 2009, involves the Indiana Health Information Exchange (IHIE); a community-wide health information exchange, representing a coalition of physician practices in central Indiana. IHIE will implement a regional, multi-payer, pay-for-performance and quality reporting program, based (by-and-large) on a common set of quality measures. In this project CMS claims and administrative data will be combined with data from other payers and participating providers to provide a more complete picture of the health care being provided to treated patients. It is estimated that approximately 100,000 Medicare beneficiaries in the Indianapolis area will receive treatment from an IHIE participating physician.

The IHIE project is the first large-scale Medicare study to examine the impact of a multi-payer, quality reporting and improvement, and pay-for-performance program. Findings from this program may provide insight into whether quality improvement and pay-for-performance programs are more effective in a multi-payer environment, as opposed to each payer having their own program and measures.

A second project with North Carolina Community Care Networks (NC-CCN) started January 1, 2010. NC-CCN is a non–profit organization made up of 14 regional health care networks focused on coordinating the delivery of care to the state's Medicaid-only population. NC-CCN's integrated health care delivery system includes community physicians, hospitals, health departments, and other community organizations. Under the MHCQ demonstration NC-CCN's existing coordination of care efforts, initially focused on the Medicaid population, will be expanded to include dual-eligible and Medicare-only patients in hopes of replicating the quality improvement and cost savings seen in the Medicaid-only population.

The NC-CCN project will be implemented in 26 of the 100 counties in North Carolina with 8 of the 14 physician networks participating. The first two years of the demonstration will target enrollment of the dual- eligible Medicare beneficiaries (approximately 30,000 beneficiaries) followed by enrollment of the Medicare-only population. As is the case with the IHIE project, quality and cost data will be collected by CMS on patients treated by NC-CCN providers and used to determine whether there is Medicare savings to be shared with participating physicians.

For more information, please contact Ron Deacon at 410-786-6622 or Ronald.Deacon@cms.hhs.gov.

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

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