Below please find the Fall 2007 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 Fall 2007 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 State Children's Health Insurance (SCHIP) programs.

- Recently awarded demonstration contracts and health services research grant awards.

- Newly available research reports on such timely topics as the care needs of people with multiple chronic conditions and a national evaluation of SCHIP.

I hope you find this information useful. For additional ORDI-related information, please visit our external site.

Timothy P. Love
Director, Office of Research, Development, and Information

1. *Health Care Financing Review*

Since our last newsletter, ORDI released the Fall 2007 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 edition is Pay for Performance. There are articles addressing pay-for-performance issues from financial gains and risks in pay for performance to results of CMS demonstrations examining different aspects of pay for performance. Click **here** to view the Fall edition. (There are also links on that page to previous issues.)

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

2. Current Demonstrations and Research Projects

Study to Assess the Impact of Transitioning Medicare Part B Drugs to Part D:

In September, ORDI let a contract to Acumen, LLC, to study further the issues involved with the relationship between Part B and Part D drug coverage as indicated in the Secretary's 2005 Report to Congress on Transitioning Medicare Part B Covered Drugs to Part D. (Available **here**) That report, which was mandated under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), suggested that there were a limited number of categories of drugs where it might be beneficial to consolidate coverage under one program. This study aims to better understand the financial and programmatic impacts of consolidating certain categories of similar drugs under one program. Under the base contract, this study will focus on three categories of drugs that may have the greatest potential for program consolidation: 1) certain oral drugs used in cancer treatment, 2) durable medical equipment supply drugs, and 3) vaccines.

For additional information, please contact Steve Blackwell at 410-786-6852.

Evaluation of Care and Disease Management under Medicare Advantage:

In August, CMS awarded a contract to L&M Policy Research to qualitatively assess care and disease management programs utilized by plans participating under Medicare Advantage. This study seeks to understand the type of programs and models of care and disease management utilized by the plans, the population receiving the care and disease management services, the role of the health plans, and what has been learned on the effectiveness of these programs for the Medicare population.

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

Evaluation of Payment Demonstrations for Medicare Part D:

In August, CMS awarded a contract to Acumen, LLC, to evaluate four Medicare Part D payment demonstrations. Specifically, we seek to assess: 1) the effect of late enrollment penalty (LEP) waivers on Part D enrollment and Medicare costs. This demonstration waives LEP for beneficiaries receiving the low-income subsidy (LIS; both full and partial subsidies) and individuals affected by Hurricane Katrina during 2006 and 2007, with an extension to 2008; 2) the impact of phasing in the weighted average, by plan's prior enrollment, calculation of the regional low-income benchmark premium over a multi-year period on low-income beneficiaries' need to change plans or pay higher premiums, and on Medicare administrative costs; 3) the impact of phasing in the weighted average calculation of the Part D plans' national average bid on beneficiaries' need to change plans or pay higher premiums, and whether maintaining stable beneficiary

premiums result in more accurate bidding by Part D sponsors; and, 4) the efficiency and economy between the two systems (state-to-plan (S2P) and contractor-based point-of-sale (POS)) currently in operation to eliminate lapses in Part D coverage for full dual eligible and LIS beneficiaries due to delays in receipt of eligibility information.

For more information, please contact Iris Wei at 410-786-6539.

Evaluation of Medical Savings Account (MSA) Plans Offered under the Medicare Program:

ORDI recently awarded a contract to L&M Policy Research, Inc to design and implement a qualitative evaluation of the types of MSA plans offered under the Medicare program. Through this study, we seek to understand the additional choices available beyond the standard fee-for-service Medicare and the other Medicare Advantage (MA) plans. This evaluation will entail a comparison of the Medicare enrollees in the MA and demonstration MSA plans with the Medicare beneficiaries in fee-for-service and the other MA plan types.

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

Medicare Home Health Pay For Performance (HHP4P) Demonstration:

Under the demonstration, home health agencies (HHAs) will be eligible to receive incentive payments if their quality improvement efforts result in the highest performance levels or if they realize significant improvements in patient outcomes. The availability of incentive payments will depend on whether or not the demonstration results in improvements in the quality of care and the actual savings to the Medicare program overall - not just for home health services, but for all Part A and Part B services in the demonstration. It is expected that system-wide savings can be achieved when a home health agency prevents a re-hospitalization of the Medicare beneficiary or a further complication stemming from an illness. Since the payments will be funded out of Medicare savings, none of the participating organizations will face payment reductions as a result of their participation in the demonstration.

CMS is now soliciting home health agency sites to voluntarily participate in the demonstration, with the actual demonstration performance period to begin January 1, 2008, and operate through December 31, 2009. The states selected for the HHP4P demonstration include Connecticut, Massachusetts, Alabama, Georgia, Tennessee, Illinois, and California.

For additional information, please contact Jim Coan at 410-786-9168 or visit the demonstration website **here**.

3. New Research Reports Published

- "The Impact of a Change in Medicare Reimbursement Policy and HEDIS Measures on Stage at Diagnosis among Medicare HMO and Fee-for-Service Female Breast Cancer Patients" by Elizabeth B. Habermann, M.P.H., Beth A. Virnig, Ph.D., M.P.H., Gerald F. Riley, M.S.P.H., Nancy N. Baxter, M.D., Ph.D., in *Medical Care* Vol. 45, no. 8, August 2007, pp. 761-766.

  Description: *This study was conducted to examine the effects of health plan enrollment (health maintenance organization (HMO) or fee-for service (FFS)), a change in Medicare reimbursement policy which allowed for annual rather than biennial mammograms, and HEDIS measures on stage at diagnosis among older women with breast cancer.*

  Researchers identified 20,106 women enrolled in FFS Medicare, and 10,751 women enrolled in an HMO. Women ages 65 through 74 and enrolled in a Medicare HMO were more likely to be diagnosed at an early stage both prior to and following the policy change, but the disparity decreased from 4.7 percent to 2.3 percent, a relative change of 51.1 percent. The disparity was not specific to the ages included in the HEDIS measure. The findings were that a decrease of 51.1 percent in the HMO-FFS disparity in breast cancer stage at diagnosis coincided with the 1998 change in Medicare mammography reimbursement policy. The existence of HEDIS measures for HMOs does not create a disparity in stage at diagnosis between those whose mammograms are measured by HEDIS (younger women) and those whose mammograms are not (older women).

  For more information contact: Gerald Riley at 410-786-6699.

- "The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions" Rick Kronick, Ph.D., Melanie Bella, Todd P. Gilmer, Ph.D., and Stephen A. Somers, Ph.D.

  Description: This paper, published by the Center for Health Care Strategies (CHCS), with data support from ORDI, examines the patterns of multiple chronic conditions among Medicaid beneficiaries using CMS Medicaid Analytic eXtract (MAX) data files.

  The CHCS analysis sought to answer two key questions:

  - *What is the prevalence of chronic conditions within the Medicaid population; and*
  - *Are there patterns of these conditions that can inform the development of more appropriate guidelines, care models, performance measurement systems, and reimbursement methodologies?*

The authors found that beneficiaries with three or more chronic conditions are responsible for a significant portion of Medicaid spending. The findings shed light on how Medicaid stakeholders can rethink care management approaches for high-need, high-cost beneficiaries with multimorbidity. Traditional disease management programs focused on single diseases that "silo" beneficiaries into disease specific interventions do not address the complex needs of those with multiple conditions. By clearly identifying the complex needs of these beneficiaries, states, plans and providers can develop integrated and coordinated delivery systems that incorporate clinical care with behavioral and non-medical supportive services.

The report is available **here.**

For more information, contact Bill Clark at 410-786-1484.

- "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access" by Margo Rosenbach, Carol Irvin, Angela Merrill, Shanna Shulman, John Czajka, Christopher Trenholm, Susan Williams, So Sasigant Limpa-Amara, Anna Katz, Mathematica Policy Research, Inc.

  Description: *CMS contracted with Mathematica Policy Research, Inc., (MPR) to conduct a national evaluation of SCHIP. In addition to providing CMS with input to its SCHIP report to Congress, the national evaluation of SCHIP also contained seven other components: (1) analysis of SCHIP enrollment, disenrollment, and reenrollment patterns based on the SCHIP Enrollment Data System (SEDS) and the Medicaid StatisticalInformation System (MSIS); (2) analysis of trends in the number and rate of uninsured children based on the Current Population Survey (CPS); (3) synthesis of published and unpublished literature about retention, substitution (also referred to as "crowd out"), and access to care in SCHIP; (4) special studies on outreach and access to car ebased on the state SCHIP annual reports; (5) analysis of outreach and enrollment effectiveness using quantitative and qualitative methods; (6) case study of program implementation in eight states; and (7) analysis of SCHIP performance measures.*

  The report is available **here.**

  For more information, contact Susan Radke at 410-786-4450.

4. ORDI Presentations

Throughout the year, ORDI seeks to work closely with other members of the research community and to share key findings in research and policy with health

service researchers and policy analysts. Below is a description of recent collaborative efforts and presentations.

- *Potentially Preventable Hospitalizations Among Medicare Home Health Patients* by Ann Meadow, Sc.D., ORDI, Centers for Medicare & Medicaid Services, and Judith Sangl, Sc.D., Agency for Healthcare Research and Quality, Poster Presentation at "2007 AHRQ Annual Conference: Improving Healthcare, Improving Lives"

Currently, a risk-adjusted hospitalization measure is included in Medicare's outcomes measurement system for home health services and reported on Medicare's Home Health Compare Website. This preliminary study applied the AHRQ adult Prevention Quality Indicators (PQIs) to explore potentially preventable hospitalizations of beneficiaries that occur within 30 days of admission into Medicare home health services. Approximately 17 percent of all home health admissions incur a hospitalization within the 30-day period. PQIs are used to identify ambulatory care sensitive conditions—conditions for which good outpatient care can potentially prevent the need for hospitalization or medical complications. Potential applications of preventable hospitalization algorithms include pay-for-performance programs and extensions of current outcomes measurement methodologies. Results from a 2003 sample and a 2005 sample suggested that up to 30 percent of all hospitalizations among Medicare home health patients within 30 days of admission were PQI-related. Congestive heart failure was the leading PQI category in 2005, followed by bacterial pneumonia, dehydration, chronic obstructive pulmonary disease, urinary tract infection, and diabetes. Preliminary data on patient demographic characteristics suggested that males and rural residents were at higher risk of a PQI-related stay than females and urban residents. Future work in developing PQI's for application to home health patients should include methods of distinguishing likely unavoidable hospitalizations from avoidable ones, in view of the poor health status of many home health users.

Slides from the presentation are available **here**.

For more information, contact Ann Meadow at 410-786-6602.

- *Understanding the Potential for Medicare Health Support* presented by Mary Kapp, ORDI, Centers for Medicare & Medicaid Services, Poster Presentation at "Disease Management Leadership Forum" in Las Vegas on September 17, 2007.

Presented were findings on *The Evaluation of Phase I of Medicare Health Support (Formerly Voluntary Chronic Care Improvement) Pilot Program Under Traditional Fee-for-Service Medicare* Report to Congress by Nancy

McCall, Jerry Cromwell, and Shulamit Bernard of RTI International, June 2007. (Report available **here**.)
Section 721(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established the Voluntary Chronic Care Improvement Programs under Traditional Fee-for-service Medicare. These programs have been implemented by CMS under the name Medicare Health Support. This interim report serves as the first of four Reports to Congress on this program and presents an overview of the scope of the programs, their design and early implementation experience, as well as preliminary cost and quality findings through the first six months of operations. Eight organizations implemented care management programs in different geographic regions beginning between August 1, 2005, and January 16, 2006. In each region, approximately 30,000 Medicare beneficiaries with heart failure or diabetes were identified as eligible; 20,000 were offered the intervention and the remaining 10,000 serve as a comparison population. The population selected is frail, with multiple comorbidities and high utilization of health care services. The organizations vary in how they engage beneficiaries and approach meeting their needs. Participation rates in the first 6 month period range from 65 percent to 92 percent. Participating beneficiaries tend to be a healthier subset of the intervention group. Within the first 6 months of operations, the programs have made only modest progress toward achieving targets for savings to the Medicare program, far less than their management fees. At this point, it is too early to assess the programs' impact on clinical quality or beneficiary satisfaction.

Slides from the presentation are available **here**.

For more information, contact Mary Kapp at 410-786-0360.

5. HBCU and Hispanic Health Services Research Grants Awards

ORDI recently made two awards under its Historically Black Colleges and Universities (HBCU) Grants Program and two awards under its Hispanic Health Services Research Grants Program.

Under the HBCU Grants Program, Meharry Medical College was awarded $250,000 to develop and test an intervention for prostate cancer screening in low-income African American males. Tennessee State University was also awarded $250,000 under this program to conduct a community-based intervention project to assess whether a telephone patient navigator model is effective for improving diabetes self-management, metabolic control, and quality of life among older African Americans with type 2 diabetes mellitus.

Under the Hispanic Health Services Research Grants Program, Arizona State University was awarded $250,000 for a project aimed at increasing Latino mothers' access to inter-conception care as a means of enhancing the overall well-

being of the mothers and their children. Under the same program, California State University at Long Beach was awarded $250,000 for an AIDS prevention program project designed to educate and empower Latino communities.

For more information on any of these grants, contact Richard Bragg at 410-786-7250.

6. Medicare Advantage Quality Measurement and Performance Assessment Training Conference – April 2008

The Medicare Health Outcomes Survey (HOS) is hosting a 2-day training conference, addressing salient topics in Medicare Advantage(MA) Quality Measurement (QM) and Performance Assessment (PA).

The training conference is open to CMS staff, MA health plan professionals, Quality Improvement Organization professionals, health services researchers, and health care policy professionals. Participants will gain insight into CMS quality reporting requirements and how to apply quality and outcomes metrics to improve performance. Experts will discuss the timely issues of pay-for-performance, Part C and Part D report cards, and risk-based approach to auditing.

When: Tuesday, April 8, 2008, from 8:30 a.m. to 4:30 p.m. and Wednesday, April 9, 2008, from 8:30 a.m. to 12:00 p.m.

Where: Sheraton Inner Harbor Hotel, Baltimore, Maryland

What:

- CMS vision for quality improvement and performance assessment
- MA Report Cards and Best Practices
- The Role of Health Information Technology in QM and PA
- The Impact of Pay-for-Performance on QM and PA

Also featuring CMS MA policy requirements for:

- HEDIS, CAHPS, and HOS
- Medicare Part D
- Special Needs Plans

REGISTRATION: Complimentary for federal employees; for all other participants there is a $100 fee.

Please visit the **National Committee for Quality Assurance's web site** for more information and to register online. You may also contact Chris Haffer at 410-786-8764.

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