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Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
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2006 Edition

Active Projects Report

Research and Demonstrations in Health Care Financing

Theme 4

Developing FFS Payment and Service Delivery Systems

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Theme 4: Developing FFS Payment and Service Delivery Systems

Summary: All the new prospective payment systems (PPSs), e.g., skilled nursing facilities (SNFs), home health, inpatient rehabilitation, and outpatient and long-term care hospitals, are being evaluated as they proceed through the successive stages of implementation. Refinement efforts to existing PPS systems are also under way. We are also working to implement demonstrations that align hospital and physician incentives, including all-inclusive payments for hospital and physician services for specific inpatient episodes of care. In addition, we are working to implement numerous payment and service delivery demonstrations mandated by the Medicare Modernization Act.

5 Year Review of Malpractice Relative Value Units

Project No: 500-00-0017/01
Project Officer: Rick Ensor
Period: September 2003 to December 2005
Funding: $269,111
Principal Investigator: Jim Moser
Award: Task Order (RADSTO)
Awardee: Bearing Point
1676 International Drive
McLean,VA 22102-4828

Description: The purpose of this procurement is to update the Malpractice Relative Value Units (MPRVUs) associated with Part B Medicare Physician Fee Schedule services. MPRVUs are one component of a fee schedule payment that by law must be updated no less than every 5 years.

Over the past year there has been substantial media coverage associated with escalating malpractice premiums for physicians. Some physician specialties are experiencing high increases as compared to other specialties. The development of revised MPRVUs will incorporate more current, specialty-specific malpractice premium data that will make the MPRVU component of the physician fee schedule a more accurate depiction of the resources cost associated with malpractice insurance coverage.

The methodology used to incorporate the malpractice premiums of the 20 largest Medicare specialties (as measured by total Medicare utilization provided by CMS) into the final MPRVUs will be identical to the methodology that was utilized by KPMG, under contract to CMS, in the October 2000 Technical Addendum to the April 7, 1999 Report on Resource-Based Malpractice RVUs (Task Order 0038). CMS will provide this Technical Addendum to the winner of the contract.

Status: Bearing Point is currently working on various technical issues which will need to be addressed in order to complete this contract. Bearing Point has been on time with all deliverables and the contract is moving along on schedule. ■

Assessment, Refinement, and Analysis of the Existing Prospective Payment System for Skilled Nursing Facilities

Project No: 500-00-0025/02
Project Officer: Jeanette Kranacs
Period: July 2001 to July 2006
Funding: $4,890,408
Principal Investigator: Korbin Liu
Award: Task Order (RADSTO)
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Description: This project supports CMS in (1) the assessment of the feasibility of refining the current Medicare payment system for skilled nursing facilities and, if feasible, producing analyses that support these refinements, and (2) our exploration of different systems for categorizing patients and their resource allocation. It will analyze data and prepare a

report containing recommendations for possible revisions to the classification of patients in a manner that accounts for the relative resource use of different patient types.

Status: Phase I focused on the design and creation of a database. Phase II analyses support annual refinements to the payment system and analysis, testing, simulations, and making recommendations regarding potential options for modifying, restructuring, or reconfiguring the existing patient classification and payment system for skilled nursing facilities. ■

Demonstration to Improve the Direct Service Community Workforce

Project No: 11-P-92158/04-01
Project Officer: Kathryn King
Period: May 2004 to May 2007
Funding: $680,000
Principal Investigator: Sandra Mlinarcik
Award: Grant
Awardee: Seven Counties Services, Inc.
101 W. Muhammad Ali Blvd.
Louisville, KY 40202

Description: This grantee will recruit and retain DSWs by providing a paid pre-service intervention and an apprenticeship program that includes access to mentors and competency-based training. In addition, the grantee will develop activities that formally recognize the value of DSWs, and create enhancements to and promote an employee association for DSWs.

Status: The grantee is implementing its interventions. ■

Demonstration-Based Review of Physician Practice Expense Geographic Adjustment Data

Project No: 500-00-0024/16
Project Officer: Jesse Levy
Period: July 2004 to December 2005
Funding: $363,108
Principal Investigator: Gregory Pope
Steven Zuckerman
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: The purpose is two-fold. The first is to assess the validity of these geographic adjustment methods by convening groups of interested parties in two localities, as described in the law, to discuss the availability of data in these localities and nationally. The second is to assess the generalizability of the data to assist in the creation of geographic indices for practice expenses for use with the Medicare fee schedule for physician services.

Status: The project is underway. Meetings with interested parties have been held in Iowa and Maine. ■

Design, Development and Implementation of a Prospective Payment System for Inpatient Psychiatric Hospitals and Exempt Units

Project No: 500-96-0007/02
Project Officer: Carolyn Rimes
Period: May 1996 to September 2006
Funding: $3,204,477
Principal Investigator: Brandt Fries
Carl Gibson
Award: Task Order
Awardee: Michigan Public Health Institute
2465 Woodlake Circle, Suite 140
Okemos, MI 48864

Description: This project aids in the design, development, testing, and implementation of a prospective payment system (PPS) for inpatient

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Studies in Home Health Case Mix

Project No: 500-00-0032/03
Project Officer: Sharon Ventura
Period: September 2001 to December 2006
Funding: $942,602
Principal Investigator: Marian Wrobel, Ph.D.
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Description: The main purposes of this project are to further develop the case mix model used for the home health prospective payment system (PPS) implemented in October 2000 and to explore new approaches to case mix adjuster development. Some of the results may have near- or medium-term application to CMS rule-making for Medicare home health payment because they are essentially extensions of the current model. Other results are not necessarily extensions of the current model and therefore might find application in the longer-term future. Additional tasks in this project involve maintenance of the home health PPS group and other types of technical assistance. All work will be conducted using existing administrative databases.

Status: Initial analyses were conducted on a 20 percent sample of claims from the first ¾ of PPS. In 2004-2005, further analysis used the initial sample and a later, somewhat larger sample. Some analyses make use of simulated episodes from earlier periods for comparison. Analyses have been directed at such issues as: (1) performance of the existing adjuster for long-stay patients; (2) feasibility of an adjuster for supplies costs; (3) prediction of therapy costs and other approaches to accounting for high-cost therapy users; (4) performance of additional diagnosis groups and co-morbidities; (5) miscellaneous refinements of existing diagnosis groups; and (6) time trends in Outcome and Assessment Information Set item coding. Further work will include retesting interim results on the latest data available during CY2005 and assessing model performance after accounting for outlier payments. ■

psychiatric hospitals and exempt units. It also includes the integration of related resident assessment instruments into the design and implementation of a PPS for inpatient psychiatric hospitals and exempt units (i.e., psychiatric facilities).

The Balanced Budget Refinement Act of 1999 (BBRA) mandated that CMS develop a per diem PPS for inpatient hospital services of psychiatric hospitals and exempt units. This system must include a patient classification system that reflects differences in the cost and use of patient resources among such hospitals and shall maintain budget neutrality. The final regulation to implement this payment system was issued in the fall of 2004. This acknowledges the need for further research to refine the PPS, and this project will be fielding a pilot test of an assessment instrument support potential case mix refinements.

Status: The project has received OMB clearance to pilot test the assessment instrument.during the summer of 2005, and a final report will be prepared delineating the reliability and validity of the instrument and making recommendation regarding the implementation of this instrument on a national basis. In addition, recommendations regarding use of this instrument to refine the inpatient psychiatric facilities PPS will be included. ■

Design, Development, Implementation, Monitoring, and Refinement of a Prospective Payment System for Inpatient Rehabilitation

Project No: 500-95-0056/08
Project Officer: Jeanette Kranacs
Period: July 1999 to September 2004
Funding: $5,908,651
Principal Investigator: Grace Carter
Melinda Beeuwkes Buntin
Award: Task Order
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Description: The purpose of this project is to support the design, development, implementation, monitoring, and refinement of a case-based prospective payment system (PPS) for rehabilitation facilities providing services to Medicare beneficiaries. Phase I of this project has been completed. This research has supported the development of a PPS for inpatient rehabilitation. This included the assessment and development of a classification system based upon both UDSmr and MEDIRISK data and focused on the Medicare population. The project will assess the feasibility of including or considering additional MDS PAC variables and assess the potential impact of the FIM-FRG classification system and subsequent payment system.

Phase II of this contract created a national database merging the Inpatient Rehabilitation Facility Patient Assessment Instrument with CMS administrative data to analyze the case mix groups and the facility adjustments for refinements to the payment systems, as well as analysis of special cases, i.e., day and cost outliers, short stay, deaths, transfers, and interrupted stay. Phase II advised and assisted CMS in developing a monitoring system to assess the impact of the inpatient PPS and analyze the results of the staff time measurement study to assess compression. Additional tasks that were addressed in the second phase of this contract included: impact of specific departments within the facilities or exempt units, assessing the impact of technological innovations on functional groups of the payment system, analysis of ADLs to predict disability status and payment, and continued analysis of the impact of motor and cognitive variables on predicting disability status and payment. This phase continued to analyze the impact of impairment groups, with and without co-morbidities, and analyzed the impact of co-morbidities and their relationship to RICs and complexities.

Status: A work plan and interim report on Inpatient Rehabilitation Facility Prospective Payment System for Phase I is complete

Additional reports for Phase II are also available. ■

Development and Implementation of the Medicare Clinical Laboratory Services Competitive Bidding Demostration Project

Project No: 500-00-0024/19
Project Officer: Linda Lebovic
Period: September 2004 to March 2005
Funding: $473,961
Principal Investigator: John Kautter
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: The purposes of this task order are to assist CMS in the design (Phase I: demonstration design, develop solicitation and bid process, claims processing plan, management), and operation (Phase II: operate bid sites of the demonstration).

Section 302(b) of the Medicare Modernization Act amends section 1847(e) (42 U.S.C. 1395w-3) --Competitive Acquisition of Certain Items and Services, to include a demonstration project for clinical laboratory services. The demonstration must apply competitive acquisition for payment for clinical laboratory services, which would otherwise be made under Medicare Part B fee schedule. The payment basis determined for each competitive acquisition area will be substituted for the payment basis. Under this statute, pap smears and colorectal screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA) as mandated in section 353 of the Public Health Service Act are applicable.

Contracts will be re-competed every 3 years, and multiple winners are expected in each competitive acquisition area. The statute does not specify the number or location of demonstration sites. The statute does not specify an implementation date. An initial report to Congress is due not later than December 31, 2005.

Status: CMS awarded the task order contract to Research Triangle Institute (and their subcontractor Palmetto GBA, LLC) on September 30, 2004. A Technical Expert Panel (TEP) was established by, and is managed by RTI to provide expertise regarding technical, operational, and laboratory performance issues for this project. TEP members were asked to participate based on their personal expertise, and are drawn from the stakeholder community. You can obtain further information about this demonstration here:

http://www.cms.hhs.gov/researchers/demos/clinicallabdemo.asp ■

Empirical Analysis of a New Payment System

Project No: 500-00-0032/10
Project Officer: Ann Meadow
Period: September 2004 to June 2007
Funding: $878,503
Principal Investigator: Marian Wrobel, Ph.D.
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Description: The project will provide evidence about how the Medicare home health benefit is operating under PPS. Information and analysis of various payment adjustments included in the home health PPS are intended to provide a basis for evaluating possible refinement options affecting features of the home health PPS design. The project will also develop background information to enable agency staff and policymakers to understand agencies' financial performance and patterns of care under PPS for various groups of agencies and patients.

Status: The project is in the early developmental stages. ■

Quality Monitoring for the Medicare Participating Centers of Excellence Demonstration

Project No: 500-00-0032/01
Project Officer: Jody Blatt
Period: September 2001 to December 2005
Funding: $735,160
Principal Investigator: Oren Grad
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Description: The purpose of the quality monitoring project is to develop a quality monitoring process that meets the general goals of various global payment demonstrations. Included in this is the Medicare Partnerships for Quality Cardiovascular Services and Medicare Partnerships for Quality Total Joint Replacement Services. Formerly, the "Quality Partnerships" for short were referred to as the "Medicare Participating Centers of Excellence Demonstration". The process incorporates the identification and technical definition of appropriate performance measures, collection of data in a centralized database, the development and distribution of reports to provide meaningful information back to demonstration participants and CMS, and coordination of the quality consortia meetings and conferences. The Quality Partnerships Demonstration involves bundled Part A and Part B payments to premier cardiovascular and orthopedic facilities for selected procedures. The selected cardiovascular and orthopedic procedures include coronary artery bypass surgery, cardiac valve procedures, angioplasty, and knee and hip replacements. We expect that the use of global payments will align the incentives for efficiency between the hospitals and the physicians, thereby enhancing not only the efficiency, but the clinical quality of services. All of the selected demonstration sites are invited to participate in a specialty specific "quality consortia" that develops quality criteria and quantitative measures for monitoring performance during the demonstration.

Status: Implementation activities for the Medicare Quality Partnerships Demonstration (originally referred to as the "Medicare Participating Centers of Excellence Demonstration") was suspended in late 2002. No sites were operational as of that date. No further implementation activity on this demonstration is currently planned. However, the contractor did complete the required literature reviews on the status of quality measures for cardiovascular surgery, total hip and knee replacements, and general inpatient services. Further work under this contract may be used to support other global payment demonstration quality initiatives. ■

Rationalize Graduate Medical Education Funding

Project No: 18-C-91117/08
Project Officer: Sid Mazumdar
Period: February 2000 to June 2007
Funding: $839,875
Principal Investigator: Gar Elison
Award: Cooperative Agement
Awardee: Medical Education Council
P.O. Box 144101, 288 North 1460 West
Salt Lake City, UT 84114-4101

Description: Since 1997, CMS has been working with the State of Utah on a project that pays Medicare direct graduate medical education funds ordinarily received by the State's hospitals to the State of Utah Medical Education Council. These GME funds are then distributed to training sites and programs according to the Council's research on workforce needs.

Status: The Utah Medical Education Council is currently participating in the demonstration with CMS. ■

expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs were used to allocate the cost pools. For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients. The BBA also requires the Secretary to develop a refinement process to be used during each of the 4 years of the period. In the 1998 notice, we finalized the proposed methodology but stated that the PERVUs would be interim throughout the transition period. Additionally, we envisioned a two-part refinement process:

- The AMA has proposed the establishment of an RVU Practice Expense Advisory Committee to review detailed, Current Procedural Terminology code level input data.

- CMS will request contractual support for assistance on methodology issues.

This project provides that contractual support.

Status: The AMA has discontinued its SMS survey of physician practices. CMS staff

and the contractor plan to meet with AMA staff to discuss various approaches

to surveying physicians to obtain practice expense data. ■

Psychiatric Inpatient Routine Cost Analysis

Project No: 500-95-0058/13
Project Officer: Frederick Thomas
Period: September 2000 to December 2004
Funding: $2,432,014
Principal Investigator: Jerry Cromwell
Award: Task Order
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The BBRA (1999) requires the Secretary to report on a per diem-based PPS with an adequate patient classification system for psychiatric hospitals and distinct part units by October 1, 2001. Previous research on inpatient psychiatric cost variation focused on explaining per case cost differences, primarily using DRGs. However, little, if any, research has been done on psychiatric per diem cost variation. Three inpatient cost components are recorded in the Medicare cost report: ancillary, overhead, and general routine care (Adults and Pediatrics). The largest of these components, general routine care, represents about two-thirds of the total cost of delivering inpatient services in exempted psychiatric facilities. Unfortunately the cost report does not detail the services that are provided in this cost category. In order to understand the dynamics of psychiatric per diem cost variation, and in particular, the variation in per diem routine costs, basic data collection and analytical work will be conducted under this project. These data will be used to construct a typology of routine inpatient psychiatric services. The variations in these services will then be analyzed at the patient level to answer the following questions:

- Do routine services vary across facility types?
- Do routine services differ between homogeneous patient categories holding facility group constant?
- How do different staffing models influence routine cost variation?
- How do patient types influence resource usage?
- How does resource intensity vary within a patient stay?
- What patient level factors affect resource usage?

Facility- and patient-level data will be gathered at over 40 sites by the end of the contract period. Data is collected for a one-week period during each of three shifts (24/7).

Status: The final project report is being reviewed. ■

Environmental Scan for Selective Contracting Practices with Efficient (Qualified) Physicians and Physician Group Practices; Profiling Techniques; Incentive Payments and Barriers to Selective Contracting

Project No: 500-00-0030/01
Project Officer: Jesse Levy
Period: September 2001 to December 2006
Funding: $493,774
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: This project undertakes an environmental scan of physician service payers/employers to identify (a) recent fee-for-service payer and managed care plan selective contracting arrangements with efficient/high quality physicians and physician-group practices; (b) best practice profiling methodology/criteria used in selective contracting including financial profiling; (c) barriers to selective contracting such as "any-willing-provider" or "freedom-of-choice" laws; and (d) bonus arrangements being paid to high quality physicians. Descriptive and qualitative analyses based on this environmental scan should lead to a recommendation of best practice profiling criteria that identify efficient and qualified physicians and group-practices. Quantitative analyses estimate current Medicare (Part B) physician expenditures and simulate possible program savings (losses) from alternative selective contracting policies based on best industry practice found in the environmental scan. The use of physician profiling (quality and economic) by payers and employers in evaluating physicians for the purposes of staff appointment, reappointment and/or selective contracting has been suggested as an accepted industry practice that would modernize Medicare payment practices. In addition, the use of bonus payments to efficient and high quality physicians to keep Medicare program costs down and quality of service up is cited as another industry practice appropriate for modernization of Medicare.

Status: The contractor completed Phase I of the project, and a final report was delivered December 31, 2003. ■

Evaluation of Competitive Bidding Demonstration for DME and POS

Project No: 500-95-0061/03
Project Officer: Ann Meadow
Period: September 1998 to December 2005
Funding: $2,315,249
Principal Investigator: Sarita Karon, Ph.D.
Thomas J. Hoerger, Ph.D.
Award: Task Order
Awardee: University of Wisconsin - Madison
750 University Avenue
Madison, WI 53706

Description: In 1999 the Agency mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics, and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use marketplace competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the project was conducted under that authority. The initial site of the demonstration was Polk County, Florida. A second site, San Antonio, Texas, was added in 2000. Competitively-bid product categories in Polk were oxygen supplies and equipment, hospital beds, enteral nutrition, surgical dressings, and urological supplies. Product categories in Texas were oxygen supplies and equipment, hospital beds, manual wheelchairs, nebulizer drugs, and non-customized orthotics. Medicare contracts with winning suppliers in Polk County commenced in October 1999, and San Antonio contracts were scheduled to commence in February 2001.

Section 4319 of the BBA specifically mandated evaluation studies addressing competitive bidding impacts on expenditures, quality, access,

and diversity of product selection. This task order studied these and other outcomes of the demonstration. The evaluation used several types of research designs, such as multiple time series analysis and pre-test/post-test comparisons.

Status: The evaluation project addressed the impacts of competitive bidding in the four mandated evaluation areas and also considered market competition and administrative feasibility. CMS released the final Report to Congress in October 2004 and added it to the CMS website.

The evaluation team estimated approximately 19 percent savings in Medicare expenditures for the goods and services involved. Estimated savings of $2.7 million (net of program costs) could grow substantially with the addition of further competitive bidding areas. Before/after survey findings and other data sources uncovered little or no adverse impact on health care access or quality. Survey data and claims analysis suggested the demonstration resulted in lower provision of portable oxygen in one site (Polk County) but not in the other site (San Antonio). Anecdotal data from site visit informants in San Antonio suggested some wheelchair suppliers attempted to cut costs by providing fewer accessories and/or charging for accessories previously provided gratis, and perhaps by using less-qualified staff for fitting. These findings, while not conclusive, imply that certain categories of DMEPOS may need special monitoring and more explicit supplier standards in the future. Claims analysis and site visit results suggested little or no impact on market competition measures under the competitive bidding experiments. The CMS demonstrated operational feasibility of DMEPOS competitive bidding in two sites under the demonstration. No major difficulties surfaced during various phases, from site preparation and public education to claims processing and monitoring. The multiple-winner design appeared key in achieving these results. Overall, the evaluation results suggested that Medicare's policy objectives in terms of savings, access, quality, competition, and administrative feasibility were largely realized in the competitive bidding demonstration. ■

Evaluation of Issues Related to Prospective Payment System under Consolidated Bidding for Skilled Nursing Facilities and Home Health Agencies

Project No: 500-96-0026/14
Project Officer: Cindy Murphy
Period: August 1999 to May 2004
Funding: $938,370
Principal Investigator: Frank Spruill, George Kowalczyk, Sam McNeill
Award: Task Order (ADP Support)
Awardee: Jing Xing Technologies, PO Box 6655, 1312 Vincent Place, McLean, VA 22106-6655

Description: This project provides analytical support for CMS on operating issues (claims processing, medical review (MR), and data processing) for providers and contractors (intermediaries, carriers, and Durable Medical Equipment Regional Carriers) that is related to implementation of skilled nursing facility (SNF) Part A prospective payment system, consolidated billing under Parts A and B, and implementation of the new SNF Part B fee schedule. Operating issues include

- intermediary medical review processes;

- avoiding duplicate payments;

- implementing the SNF Part B fee schedule;

- editing criteria and processing rules for SNF claims;

- training materials; and

- consolidating billing for home health issues.

Status: A report submitted with recommendations is available. Remaining activities include:

- Complete development of automation for fiscal intermediary MR;

- Complete development of enhanced coverage edits for FY 2001 resource;

- Complete development of specifications for focused MR for FY 2001 resource utilization

- A nationally uniform conversion factor that converts the relative value units (RVUs) into payment amounts for services.

The RVUs for each service reflect the resources involved in furnishing the three components of a physician's service:

- Physician work (i.e., a physician's own time and effort).

- Practice expenses net of malpractice expenses.

- Malpractice insurance expenses.

The original practice expense RVUs were derived from 1991 historical allowed charges. A common criticism was that for many items these RVUs were not resource-based because they were not directly based on the physician's resource inputs. CMS was required to implement a system of resource-based practice expense relative value units (PERVUs) for all physicians' services by 1998. The Balanced Budget Act of 1997 (BBA) made a number of changes to the system for determining PERVUs, including delay of initial implementation until 1999 and provision for a 4-year transition. To obtain practice expense data at the procedure code level, CMS convened Clinical Practice Expert Panels (CPEPs). The CPEPs provided the direct inputs of physician services, i.e., the amount

of clinical and administrative staff time associated with a specific procedure and medical equipment and medical supplies associated with a specific procedure. In June 1997, we published a proposed rule for implementing resource-based practice expense payments. The methodology incorporated elements of the CPEP process to develop the direct expense portion of the PERVU. The indirect expense portion of the PERVU was based on an allocation formula. In addition to delaying the implementation of resource-based practice expense payments until January 1, 1999, the BBA phased in the new payments over a 4-year transition period. In developing new practice expense RVUs, we were required to:

- Utilize, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be linked to specific procedures.

- Use actual data on equipment utilization and other key assumptions.

- Consult with organizations representing physicians regarding methodology and data to be used.

- Develop a refinement process to be used during each of the 4 years of the transition period.

In June 1998, we proposed a methodology for computing resource-based practice expense RVUs that uses the two significant sources of actual practice expense data we have available: CPEP data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. This methodology is based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physicians' services across specialties. It then allocates these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach. We used actual practice expense data by specialty to create six cost pools: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools:

- We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category.

- We determined the total number of physician hours, by specialty, spent treating Medicare patients.

- We then calculated the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours.

For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group. For group one, which includes clinical labor, medical supplies, and medical equipment, we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively. For group two, which includes administrative labor, office expenses, and all other

dental care, and vision care. These were not offset by decreases in emergency and hospital usage. ■

NF: Demo to Improve Direct Service Community

Project No: 11-P-92212/03-01
Project Officer: Kathryn King
Period: May 2004 to May 2007
Funding: $1,403,000
Principal Investigator: Diana Thorpe
Award: Grant
Awardee: Virginia, Department of Medical Assistance Services
600 East Broad St, Suite 1300
Richmond, VA 23219

Description: This grant supports work in testing interventions to recruit and retain Direct Care Workers.

Status: The project is underway. ■

NF: Demo to Improve Direct Service Community

Project No: 11-P-92243/00-01
Project Officer: Kathryn King
Period: May 2004 to May 2007
Funding: $1,403,000
Principal Investigator: Minday Schaffner
Award: Grant
Awardee: Home Care Quality Authority
640 Woodland Sq. Loop SE, P.O. Box 40940
Olympia, WA 98504

Description: This grant supports work in testing interventions to recruit and retain Direct Care Workers.

Status: The project is underway. ■

NF: Demo to Improve Direct Service Community

Project No: 11-P-92175/06-01
Project Officer: Kathryn King
Period: May 2004 to May 2007
Funding: $680,000
Principal Investigator: Herb Sanderson
Award: Grant
Awardee: Arkansas, Department of Human Services
329 Donaghey Plaza South, PO Box 1437
Little Rock, AR 72203

Description: This grant supports work in testing various interventions to recruit and retain Direct Care Workers.

Status: The project is underway. ■

Practice Expense Methodology

Project No: 500-2004-00054C
Project Officer: Ken Marsalek
Period: June 2004 to June 2006
Funding: $324,943
Principal Investigator: Allen Dobson
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule. Until January 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. In 1989 Congress established a fee schedule for the payment of physicians' services. Under the formula set forth in the law, the payment amount for each service is the product of three factors:

- A nationally uniform relative value.

- A geographic adjustment factor for each physician fee schedule area.

groups;- Complete development of query file for SNFs to ascertain Part A and Part B

status of specific CMS Common Procedure Coding System codes;

- Complete development of paid claims data analysis related to potential

duplicate payment of SNF claims;

- Miscellaneous other data analysis reports. ■

Evaluation of New Jersey Hospital Association Demonstration of Performance Based Incentives

Project No: 500-95-0048/07
Project Officer: Benson Dutton
Period: September 2002 to September 2005
Funding: $498,104
Principal Investigator: Gregory Pope
Steven Garfinkel
Award: Task Order
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The purpose of this evaluation is to provide CMS with timely feedback on the implementation and operational experience of a Medicare demonstration project on performance-based incentives. A case study methodology will develop both qualitative and quantitative information to assess the strengths and weaknesses of the demonstration.

Status: This project was formerly called "Evaluation of the Competitive Pricing Demonstration - Phase I." In April 2004, a permanent injunction was placed on the three-year project, which offered performance-based incentives to physicians who help their hospitals reduce inpatient costs. ■

Evaluation of the New Jersey Hospital Association Demonstration of Performance Based Incentives: Part 2.

Project No: 500-00-0024/15
Project Officer: Benson Dutton
Period: September 2003 to September 2005
Funding: $148,349
Principal Investigator: Jerry Cromwell
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: The goal of the demonstration is to test the feasibility and cost-effectiveness of incentive payments to physicians for inpatient procedure episodes. The demonstration hospitals will be permitted to set savings goals and make incentive payments to physicians when the goals are achieved. The evaluation of the demonstration will assess the overall performance of these hospitals over the course of the demonstration period. The evaluation of the demonstration is intended to explore the overall potential of this alternative payment approach as a means to provide health care at reduced prices by providing the opportunity for lower-cost but more coordinated service delivery through more flexible use of resources and streamlining administrative procedures without compromising quality or sacrificing patient satisfaction. This demonstration and its evaluation should provide additional operational information about this payment method for both the public and private sector.

The demonstration is currently extended to a second state, Virginia, where it will examine heart surgery under the rubric 'Virginia Cardiac Surgery Initiative'. The evaluator will be the same as for the New Jersey demonstration. Proposed funding for the Virginia part of the evaluation is $313,675 for two years.

Status: The Centers for Medicare & Medicaid Services (CMS) had begun to implement the demonstration both in New Jersey and in Virginia. In April 2004, a permanent injunction was

placed on the three-year project, which offered performance-based incentives to physicians who help their hospitals reduce inpatient costs, based on the argument that the program created an uneven playing field that favored a select group of hospitals. Nor are we going to move ahead with VA for the reasons that have recently become apparent—in particular, issues surrounding distribution of physician payments by the hospital and DHHS/OIG rules about incentive payments. There is some chance the demo could be reinstated, though not soon. The VCSQI principals are currently looking for other sources of additional money as well as potential Congressional action to give them a waiver from CMP laws, anti-kickback, etc. Citing the reasons given above we have decided to terminate the contract at this time. ■

Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions

Project No: 500-95-0058/10
Project Officer: William Buczko
Period: September 1999 to April 2005
Funding: $1,692,751
Principal Investigator: Jerry Cromwell
Award: Task Order
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: This is a coordinated evaluation of a major demonstration which provided incentives for New York State teaching hospitals to reduce their residencies by 20 to 25 percent over a 5-year period, and several provisions of the Balanced Budget Act of 1997 (BBA), aimed at reducing Medicare graduate medical education (GME) spending. Medicare annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The evaluation assesses the impacts of residency reduction on access and service delivery as well as effects on hospital fiscal status, and physician work force size and composition.

Status: Recommended Design and Strategy for NY-GME Demonstration and National BBA GME Provisions is available from the National Technical Information Service, accession number PB99-175063. There are a series of reports available, including a summary report on the New York-GME demonstration during the period from July 1, 1997, through December 31, 2003. The final report is due in 2005. ■

Impacts Associated with the Medicare Psychiatric PPS

Project No: 500-00-0024/18
Project Officer: Frederick Thomas
Period: September 2004 to March 2006
Funding: $649,970
Principal Investigator: Jerry Cromwell
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: To understand how the flow of patients between the inpatient and outpatient modalities has changed as a result of changes to a prospective payment system, as well as to understand changes in the delivery of mental health care in the last decade, this project seeks information in the following specific areas:

• The role played by smaller psychiatric inpatient units and facilities.

• The use of partial hospitalization and outpatient programs in complementing and substituting for inpatient care.

• The use of two prospective payment systems to pay for essentially the same inpatient services.

Status: The project is underway. ■

delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress has extended the demonstration several times. More recently, the Balanced Budget Act of 1997 extended the demonstration until December 31, 2000; the Balanced Budget Reconciliation Act of 1999 extended the demonstration until December 31, 2002; and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended it until December 2004. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended the demonstration until December 21, 2006. The demonstration does not accept new participants and is restricted to those who were in the program as of 1997.

Currently, there are under 25,000 Medicare beneficiaries remaining in all the sites that are eligible to participate in the demonstration. However, the number of unduplicated claims for the four sites totaled under 8,000 participants in the most recent year. The number of claims has been decreasing at the rate of about 2,000 per year. An earlier evaluation of the cost-effectiveness of the demonstration indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care. These were not offset by decreases in emergency and hospital usage. ■

Municipal Health Services Program: San Jose

Project No: 95-P-51000/09
Project Officer: Michael Henesch
Period: June 1978 to December 2006
Funding: $0
Principal Investigator: Laura Talavera
Award: Service Agreement
Awardee: City of San Jose
151 West Mission Street
San Jose, CA 95110

Description: This project supports the Municipal Health Services Program (MHSP), originally established through a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

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Municipal Health Services Program: Cincinnati

Project No: 95-P-51000/05a
Project Officer: Michael Henesch
Period: June 1978 to December 2006
Funding: $0
Principal Investigator: Daryl Cammerer
Award: Service Agreement
Awardee: City of Cincinnati
3101 Burnet Avenue
Cincinnati, OH 45229

Description: This project supports the Municipal Health Services Program (MHSP), originally established through a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower-cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

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Municipal Health Services Program: Milwaukee

Project No: 95-P-51000/05
Project Officer: Michael Henesch
Period: June 1978 to December 2006
Funding: $0
Principal Investigator: Samuel Akpan
Award: Service Agreement
Awardee: City of Milwaukee
841 North Broadway
Milwaukee, WI 53202

Description: This project supports the Municipal Health Services Program (MHSP), originally established through a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of

Improve Healthcare Access to Recovering Alch HOPE Worldwide

Project No: 18-P-92418/03-01
Project Officer: Carl Taylor
Period: September 2004 to September 2006
Funding: $24,683
Principal Investigator: Marilyn Patton
Award: Grant
Awardee: HOPE Worldwide Pennsylvania
2239 West Broadstreet
Philadelphia, PA 19132

Description: The objective of this project is to increase access to healthcare for persons addicted to drugs and/or alcohol and their families. The grant is coordinated as a Congressional mandate provided during the Agency's annual appropriations cycle.

Status: The project is underway. One year no-cost extension approved; grant end date changed to 9/9/06. Annual project report submitted on 9/30/05. ■

Improving Educational Attainment

Project No: 18-P-92308/07-01
Project Officer: Carl Taylor
Period: August 2004 to August 2005
Funding: $24,683
Principal Investigator: Michael DeBaun
Award: Grant
Awardee: Washington University
660 South Euclid Avenue
St. Louis, MO 63110

Description: The project has 2 major objectives:

1. Enhance the existing summer camp experience for children with sickle cell disease.

2. Identify counselors and junior counselors for Camp Crescent who are to be mentored for one year.

Status: The project is underway. ■

Integrated Payment Option Support Contract

Project No: 500-00-0024/06
Project Officer: J. Donald Sherwood
Period: September 2002 to September 2007
Funding: $658,775
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: This demonstration utilizes the capabilities of integrated delivery systems by offering a financial incentive to manage care and integrate services for beneficiaries across an entire defined episode of care. One example of an "episode of care" is inpatient treatment and post-acute care for stroke where the patient would benefit from improved coordination of the range of services required for this diagnosis. A single episode payment would cover Part A (all benefits available to the covered population) and Part B (physician and possibly other services covered under Part B). This demonstration will compare alternate methods for calculating payment rates using different assumptions such as co-morbid conditions, stage of diagnosis, and mix of services.

Status: Several tasks under this contract have been postponed and/or delayed. The contractor is currently concentrating on the task of developing a Post Acute Integrated Payment demonstration to be implemeted in the Mercy Medical network of post acute providers in Alabama. This system will cover services providee in inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies. ■

Long Term Care Hospital Payment System Refinement/Evaluation

Project No: 500-00-0024/20
Project Officer: Judith Richter
Period: September 2004 to September 2006
Funding: $361,503
Principal Investigator: Barbara Gage
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Description: The contractor shall provide a wide variety of statistical data and policy analysis to support CMS's need to further examine the LTCH PPS and its effect on overall Medicare payments. In addition, the expansion is needed for the statement of work for the QIOs in order for them to monitor LTCH compliance with the newly established hospital and patient criteria.

Status: The project is underway. ■

Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes

Project No: 500-96-0006/04
Project Officer: Philip Cotterill
Period: September 2000 to September 2005
Funding: $636,557
Principal Investigator: Brian Burwell
Barbara Gage
Award: Task Order
Awardee: MEDSTAT Group (DC - Maryland Ave.)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Description: The purpose of this project is to study the impact of BBA and other policy changes on Medicare utilization and delivery patterns of post-acute care. Post-acute care is generally defined to include the Medicare covered services provided by skilled nursing facilities (SNFs), home health agencies, rehabilitation hospitals and distinct part units, long-term care hospitals, and outpatient rehabilitation providers. The changes in post-acute care payment policy enacted in the late 1990's (mostly in the 1997 Balanced Budget Act (BBA) with some subsequent modifications) were made one-by-one to most types of post-acute care. However, a beneficiary's post-acute care needs can often be met in alternative provider settings. Hence policy changes for one post-acute care modality may have ramifications for other post-acute and acute care services. Understanding the interrelationships among post-acute care delivery systems is critical to the development of policies that encourage appropriate and cost-effective use of the entire range of care settings. The results of this work may be useful in refining policies for individual types of post-acute care, as well as in developing a more coordinated approach across all settings. This initial project will compare changes between the pre-BBA period of the 1990's and the post-BBA year, 1999. The study will include a variety of beneficiary, provider, and market area analyses. Since the full effect of policy changes not yet implemented will continue to build for many years, the analyses developed under this contract are expected to use and refine methods that can be applied in future evaluation research.

Status: The final report containing descriptive and multivariate analyses of post-acute episodes of care during the period 1996-2002 is expected by September 2005. The final report will comprise four separate reports: an analysis of the issues raised by the BBA post-acute policy changes; an analysis of the post-acute transfer policy; a report on changes in the number of post-acute providers, 1996-2001; and an analysis of the impact on access to care of rate adjustments under the SNF PPS. ■

Mercy Medical Skilled Nursing Home Payment Demonstration

Project No: 95-W-00083/04
Project Officer: J. Donald Sherwood
Period: January 2002 to December 2005
Funding: $0
Principal Investigator: Kathryn Parks
Award: Waiver-Only Project
Awardee: Mercy Medical
101 Villa Drive, P.O. Box 1090
Daphne, AL 36526-1090

Description: This pilot study is viewed as a period of evaluation for the purpose of working toward crafting an alternative approach to financing post-acute care that features greater integration of services and episodic payment. During the demonstration period, Mercy Medical is being paid according to the payment methodology that was used during the 2-year period authorized by BBRA, i.e., a per diem payment based on historical cost.

Status: Mercy Medical is developing a proposal for a 5-year demonstration to test an alternative approach to financing post-acute care that features increased integration of services and a bundled payment for select diagnoses. The post-acute services include inpatient rehabilitation hospital, SNF, and home health. For qualifying Medicare patients in the diagnostic categories of cerebrovascular accident (CVA)/Stroke, Cardio-Pulmonary, and Orthopedic, Mercy Medical would be paid a single bundled payment for a defined 100-day episode of care. For Medicare patients not in the select diagnosis groups, Mercy Medical will continue to receive the inpatient rehabilitation PPS, home health agency PPS, and the waivered SNF payment as defined in BBRA. ■

Municipal Health Services Program: Baltimore

Project No: 95-P-51000/03
Project Officer: Michael Henesch
Period: June 1978 to December 2006
Funding: $0
Principal Investigator: Sherry Adeyemi
Award: Service Agreement
Awardee: City of Baltimore
111 North Calvert Street
Baltimore, MD 21020

Description: This project supports the Municipal Health Services Program (MHSP), originally established through a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress has extended the demonstration several times. More recently, the Balanced Budget Act of 1997 extended the demonstration until December 31, 2000; the Balanced Budget Reconciliation Act of 1999 extended the demonstration until December 31, 2002; and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended it until December 2004. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended the demonstration until December 21, 2006. The demonstration does not accept new participants and is restricted to those who were in the program as of 1997.

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