Care Management for High-Cost Beneficiaries Demonstration

The Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration to study various care management models for high-cost beneficiaries in the traditional Medicare fee-for-service (FFS) program. CMS will assess how well each of these programs is able to reduce Medicare costs while improving the quality of care and quality of life for beneficiaries.

Background

Fifteen percent of the Medicare FFS beneficiaries account for approximately 75 percent of the total Medicare expenditures in any given year. Many of these beneficiaries have multiple costly conditions and are at high risk of continuing to require intensive medical services. CMS has a number of planned and ongoing care coordination and disease management demonstrations and programs, but the Care Management for High-Cost Beneficiaries (CMHCB) demonstration will be the first effort to specifically focus on the high-cost FFS beneficiaries.

For some beneficiaries with high-cost conditions, the restructuring of care to integrate provider services in the program and to deliver those services in non-acute care locations such as the beneficiary's home could significantly improve the beneficiary's quality of life while simultaneously reducing costs. Under this demonstration, CMS hopes to test a variety of models such as intensive case management, increased provider availability, structured chronic care programs, restructured physician practices, and expanded flexibility in care settings.

Demonstration Design

Physician groups, hospitals, and integrated delivery systems are invited to submit proposals for this demonstration. Other types of organizations may apply, but they must be part of a consortium that includes at least one of the above-mentioned entities.

Beneficiaries eligible to participate in the demonstration are those individuals who are identified by CMS as meeting its high-cost guidelines as well as any additional targeting criteria for the individual programs. Applicants will specify the types of conditions and the demographic and other beneficiary characteristics that their care management models are designed to serve.

Applicants may propose a monthly fee to cover their administrative and/or care management costs, and they may propose a plan to share a portion of the savings from the demonstration. However, organizations failing to produce a 5 percent savings net of fees will be required to refund the savings shortfall up to the full amount of their fees. Also, proposals to share savings will be considered only for net savings in excess of 5 percent.

Medical services provided within and external to the demonstration will be covered under the regular Medicare Parts A and B. The demonstration will not in any way restrict a beneficiary's access to regular Medicare services or providers. Also, the beneficiary will assume no financial liability for the administrative and care management fees, which will be paid in full by Medicare.

Selection of Organizations

All applications will be reviewed by panels of CMS and external experts. The Administrator will make the final selection. Approximately four to six organizations will be selected to participate in this 3-year demonstration.

Evaluation of the Demonstration

An independent organization will conduct an evaluation of the demonstration. The evaluation will be based on a comparison of total claims costs plus administrative and care management fees for the intervention groups to total claims costs for the control groups. Also, the results of surveys of beneficiaries and providers as well as various quality parameters will be assessed.