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I. General Information

a. What is the Care Management for High Cost Beneficiaries Demonstration project (also known as the Care Management Demonstration)?

The Care Management Demonstration project consists of six 3-year pilot programs implemented by six Care Management Organization (CMO) Medicare awardees:

- Care Level Management
- Health Buddy
- Massachusetts General Care Management
- Montefiore Care Guidance
- RMS KEY to Better Health
- Texas Senior Trails

Collectively, the demonstration tests provider-based intensive care management services as a way to improve quality of care and reduce costs for Fee-for-Service (FFS) beneficiaries who have one or more chronic diseases. The programs support collaboration among participants' primary and specialist providers to enhance communication of relevant clinical information. They are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating complications. Each CMO has named their own project, offers their own intensive care management services, and will operate in designated states. (See CMO Project Table).

b. Why is CMS conducting this demonstration project?

Fifteen percent of 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 Demonstration is 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 settings such as the beneficiary's home could significantly improve the beneficiary's quality of life while simultaneously reducing costs. Under this demonstration, CMS tests 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.

c. Is the Care Management Demonstration part of the Medicare Modernization Act?

No. The Care Management Demonstration is not associated with the Medicare Modernization Act (MMA). This demonstration is an initiative of the Centers for Medicare and Medicaid Services (CMS).

When does the demonstration actually start operations?

The individual projects will begin after successful completion of contract negotiations and the identification of intervention and control groups. Each Care Management Organization has its own launch date (subject to change):

- Care Level Management: October 2005
- Health Buddy: Early 2006
- Massachusetts General Care Management: Early 2006
- Montefiore Care Guidance: Early 2006
- RMS KEY to Better Health: November 2005
- Texas Senior Trails: Early 2006

II. Eligibility

a. Who decides who is eligible to participate?

The Centers for Medicare and Medicaid Services (CMS) will identify the beneficiaries who are eligible to participate in the demonstration. Beneficiaries selected by CMS to participate will have to meet eligibility criteria outlined by each site, including having one or more chronic conditions. Beneficiaries selected to participate will receive an invitation letter from Medicare and will later be contacted by a Care Management Organization project staff member. (Note: invitations will go out before the start date for each project). While CMS selects the eligible beneficiaries, participation in the demonstration is voluntary.

b. Who will be invited to participate?

Centers for Medicare and Medicaid Services (CMS) pre-selects beneficiaries to participate in the Care Management Organizations' demonstration projects. The selection process is randomized, which means that only a portion of beneficiaries who meets the criteria to participate in the project will be invited. In order to be eligible for the program, at minimum individuals must:

- Be enrolled in Medicare Parts A and B;
- Reside in one of the demonstration states (CA, FL, MA, NV, NY, OR, TX, or WA);
- Meet eligibility criteria outlined by each site, including having one or more chronic conditions;
- Have Medicare as their primary payer.

c. Do I have to participate if I am invited?

No. If you are invited, you can choose not to participate in the program. Participation in this program is completely voluntary and will not affect the beneficiary's access to services or ability to choose doctors and other health care providers. If you decide to participate in the project, you can use the services offered as much or as little as you want. At anytime, you can change your mind and choose not to continue with the project.

d. My friend was invited to participate and I was not, can I participate?

No. This is a pilot program, which means it is a test and only a limited number of people can participate. Therefore, even though you may have similar health issues/conditions to your friend, only beneficiaries who were pre-selected for the program by CMS (Centers for Medicare and Medicaid Services) and received an invitation letter from Medicare and the Care Management Organization can participate at this time. If the program works well, after the three-year pilot more people may be able to get the services offered by this project.

III. Participants' Medicare Benefits

a. Will participating in the project affect beneficiaries' Medicare benefits?

No. Participating in a demonstration project will not change the amount, duration, or scope of the beneficiary's Fee-for-Service (FFS) Medicare benefits. Benefits will continue to be covered, administered, and paid under the traditional FFS Medicare program. Programs will be offered at no additional charge to the beneficiaries beyond their normal original Medicare plan co-payments and/or deductibles. Care Management Organizations cannot restrict beneficiary access to care or restrict beneficiaries to a limited number of physicians in a network.

b. I am participating in the Care Management Demonstration project. When I went to my regular provider, I was told that I am enrolled in an HMO, Medicare Advantage plan, or other non-Fee For Service health plan. Is this true?

No, this is NOT true. Participating in this program does not mean that you, the beneficiary, are enrolling in or have enrolled in an HMO, Medicare Advantage plan, or other non-Fee For Service health plan. This is NOT a new insurance plan. This does not replace original Medicare

Fee-For-Service (FFS) benefits, but provides additional support services for the participating beneficiaries. You are still insured under the Medicare FFS and your benefits will not and have not changed.

IV. Care Management Organization (CMO) Financial/Payment Arrangements

a. How does the saving guarantee work?

Each CMO must guarantee a net savings of 5 percent. Net savings will be calculated by comparing fee-for-service (FFS) payments of the control group to FFS payments plus any administrative or care management fees to the intervention group. The administrative or care management fees will be held at risk for the amount of any realized net savings less than 5 percent.

V. Evaluation

a. What is the purpose of evaluation?

The formal evaluation has two purposes. The first purpose is to specifically determine whether each Care Management Organization program was able to achieve the demonstration objectives of improving quality of care and realizing financial stability. And second, the evaluation has a broader research objective for CMS to learn what it can about these programs and the reasons for their successes. The evaluation also includes an analysis of which program features works best or which types of Medicare beneficiaries (subpopulations) are best served by the program.

b. How will Care Management Organization projects be evaluated?

An independent organization will conduct an evaluation of the demonstration. The evaluation will include 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.

c. Will the programs be evaluated compared to each other?

The primary comparisons for the evaluation will be within an individual site, rather than measuring one program against another. The intervention group for a particular site will be compared to a control population for that site.

<table>
<tr><th>Name of Project</th><th>Population Focus and Program Features</th><th>Geographic Area</th></tr>
<tr><td>Care Level Management</td><td>• Serves beneficiaries who are seniors and suffering from advanced, progressive chronic disease(s) and co-morbidities with 2 or more condition related hospital admissions in the past year.
• Provides care management via a distributed network of Personal Visiting Physicians (PVPs) who see patients in their homes and nursing facilities and are available 24 hours a day, 7 days a week.
• PVPs are supported by Personal Care Advocate Nurses who are based in nearby regional offices and who provide care coordination and maintain regular phone contact with beneficiaries.
• Patients have direct cell phone access to their PVP and Personal Care Advocate Nurse 24 hours a day, 7 days a week.</td><td>California
Texas
Florida</td></tr>
<tr><td>Health Buddy</td><td>• Serves beneficiaries with congestive heart failure, diabetes, and or chronic obstructive pulmonary disease
• Uses a technology platform. Patients receive a Health Buddy appliance that coaches them about their health, collects vital signs and symptoms, and transmits results back to multi-specialty medical groups.
• Physicians and nurses will use information provided via the Health Buddy to spot problems early and ensure patients stay healthy.</td><td>Oregon
Washington
Nevada</td></tr>
<tr><td>Massachusetts General Care Management</td><td>• Serves beneficiaries who seek care from Massachusetts General healthcare system
• Comprehensive care management by a dedicated team of doctors and nurses
• Specialized programs for patients with chronic conditions
• Home visits and home telemonitoring when needed
• Electronic medical record system assures coordination, continuity, and adherence to physician-approved care management plan</td><td>Massachusetts</td></tr>
<tr><td>Montefiore Care Guidance</td><td>• Serves beneficiaries residing in naturally occurring retirement communities regardless of where they currently receive care and FFS beneficiaries being cared for within the Montefiore healthcare network, both who have multiple chronic conditions.
• Offers enhanced home-based services to participants using telemonitoring equipment and home visit programs.
• Also offers medication management, falls prevention, palliative care, and disease management programs.</td><td>New York</td></tr>
<tr><td>RMS KEY to Better Health</td><td>• Serves beneficiaries with chronic kidney disease
• Provide intensive disease management directed by nephrologists in supplementary clinics to identify potential problems and avoid complications, coordinate early intervention plans and prevent acute hospitalization.
  o Health evaluations to identify beneficiaries' healthcare needs and any early warning signs of other conditions.
  o 24-hour phone line access to nurses to answer questions and give support.
  o Educational materials, including a newsletter.
  o Access to a Pharmacist to help understand and manage the drugs beneficiaries are taking.
  o Help to understand Medicare benefits and the prescription drug plan.
• Field based nursing support.
• Early referral to a Nephrologist</td><td>New York</td></tr>
<tr><td>Texas Senior Trails</td><td>• Beneficiaries who receive care from the Texas Tech Physician Associates primary care and specialist physicians and who are at greatest risk for readmission and adverse events in largely underserved, rural area.
• Team coordinates a home and office based program</td><td>Texas</td></tr>
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