2008 Edition

Active Projects Report

Research and Demonstrations in Health Care Financing

A Comprehensive Guide to CMS's Research Activities

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Active Projects Report

The Active Projects Report is a yearly publication that reports CMS's research activities. Throughout the year, CMS directs numerous individual research, demonstration, and evaluation projects. Our research helps to identify future trends that may influence our programs, meet the needs of vulnerable populations, and examine the cost-effectiveness of our policies. Demonstration projects test, for example, how a new payment system, preventive service, or health promotion campaign actually affect our programs, beneficiaries, States, and providers. Evaluation projects validate our research and demonstration findings and help us monitor the effectiveness of Medicare, Medicaid, and SCHIP. The Active Projects Report provides a brief description of each project and its status. It also provides an identifi cation number, the project title, the project number, the CMS project officer, the awardee,funding, principal investigator, and the period of performance. More detailed information regarding specific projects may be obtained directly from CMS project officers. This is the twenty-seventh edition of the Active Projects Report. For more information, please visit the CMS Web site at http://www.cms.hhs.gov/ActiveProjectReports.

Activities Prior to the Construction of State Medicaid Research Files (SMRFs) for 1996-1998

Project No: 500-95-0047/08
Project Officer: David Baugh
Period: September 2000 to December 2006
Funding: $2,381,124
Principal Investigator: Suzanne Dodds
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has completed work on SMRF data for 1996 to 1998 and MAX data for 1999 to 2002. Information about the MAX and SMRF data are available on the CMS web site at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp#TopOfPage.

Other contracts will continue to produce MAX data for 2003 and later years.

Description: The purpose of this contract is to have Medicaid eligibility and services claims experts develop business rules to transform Medicaid (and SCHIP) person-level data records from the Medicaid Statistical Information System (MSIS) into records in the Medicaid Analytic eXtract (MAX) system - formerly known as the State Medicaid Research Files (SMRFs). These business rules involve a number of activities related to eligibility, type of service, and combination of MSIS claims to create MAX/SMRF final action service records. This involves reviewing MSIS documentation, developing MSIS to MAX/SMRF business rules, possible interaction with State Medicaid agency personnel to gather information, clarify issues and/or devise corrective action strategies. The contractor passes the business rules to another party, known here as the MAX producer, who processes the MSIS files according to the MAX business rules to create the MAX data files. Once the MAX producer develops MAX data, this contractor performs a comprehensive assessment of data quality and validity to assure that the final MAX data are of the highest possible quality. The validation process may involve a number of iterations between the MAX producer and the contractor until data quality issues are resolved. Upon acceptance of the final MAX data files, the contractor assists the Federal project officer to prepare the data for access by the user community which includes CMS, other HHS components, other Federal and State agencies, foundations, consulting firms, and academic institutions. This includes preparation of explanatory materials on the business rules, data validation reports, data anomaly reports and limited technical consultation on data issues. Interested parties may obtain additional information at the CMS MAX web site: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp#TopOfPage ■

Actuarial Research Contract

Project No: 500-03-0021
Project Officer: Christopher Molling
Period: September 2005 to September 2008
Funding: $4,135,786
Principal Investigator: Beth Jackson
Award: Contract
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale,VA 22003

Status: The project is current and ongoing. This is the fourth option year of the contract, no additional option year is planned.

Description: This project continues to estimate ad hoc requests from the Department of Health and Human Services, Centers for Medicare and Medicaid Services, White House and U.S. Congress. Estimates are made of proposed law, statute and regulations. The project also continues the development and updating of the micro-simulation model used to support health policy analysis. This model is used by CMS to analyze impacts of changes in U.S. health care and for requirements of HIPAA. ■

ADA and Quality Initiatives

Project No: 500-00-0021/01
Project Officer: Adrienne Delozier
Period: September 2003 to September 2008
Funding: $5,083,486
Principal Investigator: Brian Burwell
Award: Task Order (RADSTO)
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: The period of performance has been extended to September of 2008. The contract has been modified to add $524,903 to the funding.

Description: On June 22, 1999, the U.S. Supreme Court, in *Olmstead v. L.C.*, provided an important legal framework for State and Federal efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. This decision affirmed that no one should have to live in an institution or nursing home if they can live in the community with the right mix of supportive services for their long-term care. The Americans with Disabilities Act of 1990 (ADA) is both reinforced and clarified with the Olmstead decision. This decision has challenged the Federal Government and States to develop more opportunities for individuals with disabilities to live and participate in the community through more accessible systems of cost-effective community-based services. The Medicaid Program plays a critical role in making long-term care available in the community by offering States many opportunities to deliver this care through mandatory State plan services like home health and optional services such as personal care. In addition, most States rely heavily on the Medicaid 1915(c), 1915(b) and 1115 waiver authorities to provide long-term care in the community.

On June 19, 2001, the President released an Executive Order aimed at expanding community-based alternatives for people with disabilities. He directed a number of Cabinet Secretaries, including the Secretary of Health and Human Services (HHS), to "swift(ly) implement the Olmstead Decision (and) evaluate the policies, programs, statutes and regulations … to determine whether any should be revised or modified to improve the availability of community-based service for qualified individuals with disabilities." Each agency head was required to report to the President, through the Secretary of HHS, the results of their evaluation. A preliminary report, entitled Delivering on the Promise, was sent to the President on December 21, 2001. Individual Agency and Department Reports were sent on March 25, 2002. The HHS Report is entitled Progress on the Promise.

This contract supports several tasks that further the goals of the ADA, the Olmstead Decision, and the New Freedom Initiative including:

1. Ensuring Quality in the Medicaid Home and Community Based Services (HCBS) Waiver Program - Provides a National Technical Assistance Contractor for the provision of technical assistance to States, the Centers for Medicare & Medicaid Services (CMS) Central Office, and CMS Regional Offices in the areas of quality management, including quality assurance and improvement.

2. Resource Network for ADA/Olmstead - Supports the website HCBS.org which facilities communication between States and consumers, provides seminal research and summaries on HCBS programs or initiatives, and provides important HCBS data.

3. Olmstead-Informational Tools for States - Funds efforts by the National Conference of State Legislatures to help legislators understand their responsibilities and opportunities to provide cost-effective, high quality community-based services, develop systems that support employment of people with disabilities, and understand then comply with the Olmstead v. L.C. Supreme Court decision.

4. Executive Order Administrative Costs - Will support the logistical planning and convening of two New Freedom Initiative Policy Summits.

5. New Model Waivers - Will develop a training curriculum for CMS to present to States on self-direction in the context of Independence Plus waivers and demonstrations and implementing the required standards. Will also support technical assistance to states on implementation and CMS requirements related to Independence Plus.

Option II was exercised in April 2006. ■

Administration of the PACE Health Survey

Project No: 500-00-0030/03
Project Officer: Louis Johnson
Period: September 2001 to December 2006
Funding: $1,566,739
Principal Investigator: Edith Walsh
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Status: During 2004, the PACE Health Survey was administered to enrollees of 27 PACE organizations. The overall response rate was 75 percent, with plan response rates ranging from 56 percent to 92 percent. These response rates were consistent with the response rates achieved for the PACE Health Survey in 2003. The functional impairment information collected by the 2004 PACE Health Survey was used to determine the frailty adjuster for each PACE organization for the purposes of Medicare payment in 2005. In the past two years, the contract was modified to add $533,845 to the funding. The contract ended in December of 2006.

Description: The purpose of this project is to implement the Health Outcomes Survey for organizations that serve special populations. In 2003 and 2004, the Program of All Inclusive Care for the Elderly (PACE) Health Survey was implemented for the PACE Program. The survey collected functional impairment information that supported frailty-adjusted Medicare capitation payments to PACE organizations for 2004 and 2005, respectively. ■

ADP Services Supporting Research, Analysis and Demonstration Activities - Base Contract

Project No: 500-02-0006
Project Officer: David Barbato
Period: September 2002 to September 2007
Funding: $0
Principal Investigator: Celia H. Dahlman
Award: Task Order Contract, Base
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

Status: The base contract has ended. Some tasks will continue to remain open.

Description: CMS's research, analytic, and demonstration projects require computer and related support services to access, manipulate, process, and develop data and files. The data files include those derived from the Medicare and Medicaid Programs as well as those from CMS contracts and grants or other sources. Current and anticipated internal resources are insufficient to handle the range and quantity of requirements that arise from these projects and from projects that will occur in the future. ■

Adverse Events Among Chronically Ill Beneficiaries: Variations by Geographic Area, Organization of Practice, and LTC Setting

Project No: HHSM-500-2005-00020I/0001
Project Officer: Carol Magee
Period: September 2005 to September 2008
Funding: $299,780
Principal Investigator: Christine Bishop
Award: Task Order (MRAD)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Data analysis for this contract is being performed.

Description: This task order will conduct analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. ■

Agreed Upon Procedures Review of XLHealth's Operational Procedrues and Expenditures Relating to the BIPA Disease Management Demonstration

Project No: GS-23F-0135L/HHSM-500-2006-00018G
Project Officer: Juliana Tiongson
Period: February 2006 to January 2009
Funding: $275,127
Award: GSA Order
Awardee: Clifton Gunderson
4041 Powder Mill RoadSuite 410
Calverton, MD 20705

Status: The period of performance has been extended through January 31, 2009.

Description: This Task Order will perform an Agreed Upon Procedures Review (AUPR) of the Disease Management Organization (DMO) to validate operational procedures and expenditures relating to the DMO's participation in the BIPA Disease Management Demonstration. ■

Analysis, Methods of Assessment, and Special Studies for the Development of a Fully Bundled Prospective Payment System for Outpatient End State Renal Disease Facilities

Project No: HHSM-500-2006-00048C
Project Officer: William Cymer
Period: September 2006 to September 2008
Funding: $965,498
Principal Investigator: Richard Hirth
Award: Contract
Awardee: University of Michigan Kidney Epidemiology and Cost Center
315 West Huron, Suite 420
Ann Arbor, MI 48103

Status: Option year one has been exercised. Fiscal year 2008 represents the first option year under this contract.

Description: This contract, with an option to extend the period of performance beyond fiscal year 2008 on an annual basis through fiscal 2011, allows the Kidney Epidemiology and Cost Center (KECC), through the Regents of the University of Michigan, to conduct end stage renal disease (ESRD) prospective payment system (PPS) research. The project involves the analysis of administrative data, case mix information, and the development of methods to monitor and refine the basic case mix adjusted PPS for outpatient ESRD facilities. This research will also build on, extend, and update previously completed phased research efforts to develop a fully bundled ESRD PPS, one that expands the routine maintenance dialysis services currently reimbursed under the composite payment system to include separately billable services. The development of a fully bundled ESRD PPS was required in accordance with section 623(f) of Public Law 108-173. ■

Application of Episode Groupers to Medicare

Project No: HHSM-500-2006-00006I/05
Project Officer: Fred Thomas
Period: August 2007 to July 2008
Funding: $444,398
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: Work to date has included review of the clinical logic of two commercial groupers. Preparation for expert panel meetings with physicians to review grouper-based resource profiles is underway.

Description: CMS's episode grouper software evaluation began in 2006. Over the last year, there has been a notable evolution in the policy environment related to episodic grouping. In particular, MEDPAC has issued two reports that suggest that episode grouping techniques have the potential to be developed into tools for profiling physician efficiency by identifying physicians whose costs per episode are outside a reasonable range. Various umbrella organizations,

such as the Alliance for Quality Activity (AQWA) and the National Quality Forum (NQF), are working to define a set of conceptual standards that can be used in constructing physician profiles. Recently, a GAO study showed that there is substantial cost variation across patients within disease types using annual claims data. An extension of this work is that physician profiles may be generated from claims data to identify those responsible for higher care costs, and then use financial incentives to change this behavior. In light of the continuing policy debate, and to test the application of these concepts in Medicare, this task order will continue the work performed under the Episodic Grouper Evaluation contract by writing a design report for a pilot study; construct physician efficiency profiles; write a report on profiling and result of the modified groupers; and provide programming/analytic support to a complementary clinical logic contract. ■

Arizona Health Care Cost Containment System

Project No: 11-W-00032/09
Project Officer: Steven Rubio
Period: July 1982 to September 2011
Funding: $0
Principal Investigator: Anthony Rodgers
Award: Waiver-Only Project
Awardee: Arizona Health Care Cost Containment System
701 East Jefferson, MD 7000
Phoenix, AZ 85034

Status: On June 29, 2007, the State submitted an amendment request to extend hospice care benefits to all adult acute care members, increase the FPL eligibility level for pregnant women and women transitioning into the Family Planning Extension Program, and provide basic and preventive dental coverage for adult members age 21 and older of the Arizona Long Term Care program. As of January 24, 2008, the amendment request was still pending.

Description: The entire Arizona Medicaid Program operates as a Medicaid Section 1115 demonstration and includes a HIFA amendment that allows for coverage of parents, children and childless adults with title XXI funds. In addition, Arizona has a targeted family planning demonstration for women with incomes up to 133 percent FPL who are otherwise ineligible for Medicaid at the end of 60 days post-partum. This demonstration permits the State the flexibility of determining the effectiveness of placing more than 95 percent of its Medicaid expenditures into managed care. ■

Arkansas 1115

Project No: 11-W-00116/06
Project Officer: Marguerite Schervish
Period: October 1998 to January 2008
Funding: $0
Principal Investigator: Deborah Ellis
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services
Division of Medical Services
PO Box 1437, Slot S401
Little Rock, AR 72203-1437

Status: On January 29, 2007, CMS approved a one-year extension of the program, from February 1, 2007 until January 31, 2008, at which time the State's section 1115 program will expire. However, with the enactment of the Deficit Reduction Act of 2005, section 6087 (codified as section 1915(j) of the Social Security Act) permits States to offer self-directed personal assistance services (PAS) as part of their Medicaid State plans obviating the need for further waiver submissions. CMS understands that Arkansas will pursue a section 1915(j) application to amend its State plan to add self-directed PAS.

Description: The National Cash and Counseling Demonstration was an innovative model of consumer-direction in the planning, selection, and management of community-based personal care and related health services. Consumers were given a monthly cash allowance that they used to purchase the assistance they required for daily living. The Cash and Counseling Demonstration and Evaluation occurred in three States: Arkansas, Florida, and New Jersey. Under the section 1115 demonstration authority of the Social Security Act and the initial design of the program, participants were assigned to a treatment group or a control group. Beneficiaries selected for the treatment group received cash allowances, which they used to select and purchase the personal assistance services (PAS) that met their needs. Fiscal and counseling intermediary services are available to those members of the treatment group who wish to utilize them. Individuals assigned to the control group received PAS services from traditional Medicaid providers, with the State making all vendor payments. Other partners in this collaborative effort included

the Robert Wood Johnson Foundation, which funded the development of these projects; the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, which funded the evaluation; the National Program Office at Boston College, which performed various coordinating functions; the University of Maryland's Center on Aging, which conducted ethnographic studies; and the National Council on Aging, which has served in an advisory capacity. An evaluation contract was awarded to Mathematica Policy Research, Inc. Mathematica assessed differential outcomes with respect to cost, quality, and client satisfaction between traditional PAS services and alternative choice modalities. These reports can be found at www.cashandcounseling.org.

CMS approved the Arkansas Independent Choices demonstration on October 9, 1998, and implementation began December 1, 1998. Enrollment and random assignment began in December 1998 and continued until the evaluation target of 2,000 enrollees in April 2001. CMS approved an amendment to the program on October 2, 2002. Since that time, the program has met the CMS requirements to be conferred the Independence Plus designation. The amendment allowed Arkansas to end randomization and to extend the program for 3 years. Participants in the control group, and others, have been given the opportunity to enroll in the treatment group. Current participation is about 1,400. On April 26, 2006, the State submitted a request to amend and extend the program. ■

Arkansas TEFRA-like Demonstration

Project No: 11-W-00163/6
Project Officer: Mark Pahl
Period: October 2002 to December 2010
Funding: $0
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services
Division of Medical Services
PO Box 1437, Slot S401
Little Rock, AR 72203-1437

Status: On December 31, 2007, the State was awarded a three year extension of the TEFRA-like demonstration, through December 31, 2010.

Description: The Arkansas TEFRA-like demonstration provides coverage for disabled children otherwise eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act. A sliding scale premium is assessed to families based on income. Services are delivered through the State's network of Medicaid providers and are reimbursed on a fee-for-service basis. The objectives of the demonstration are to determine methods to increase the attractiveness of the TEFRA option for states that have not yet adopted it and to render such optional coverage more affordable for states facing budget shortfalls. ■

ARKids B

Project No: 11-W-00115/6
Project Officer: Mark Pahl
Period: August 1997 to September 2008
Funding: $0
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services
Division of Medical Services
PO Box 1437, Slot S401
Little Rock, AR 72203-1437

Status: On September 19, 2007 the State of Arkansas requested a three year extension of the ARKids B demonstration. If approved the extension will run from October 1, 2008 through September 30, 2011.

Description: The ARKids B demonstration provides coverage for uninsured children through age 18 with family income at or below 200% FPL. Individuals can choose between the State's traditional Medicaid program and the ARKids B program. Arkids B offers a less comprehensive benefit package and requires co-payments. The demonstration utilizes the same provider system as the traditional Arkansas Medicaid program and operates as a primary care case management model. The

objectives of the demonstration are to integrate uninsured children into the health care delivery system and to provide benefits comparable to the State Employees and State Teachers Insurance Program. Funding through the program is provided through State appropriations and title XXI matching funds are claimed for enrollees who are not eligible for traditional Medicaid. ■

Assessing Colorectal Cancer Knowledge and Improving Screening Rates Among Older Minorities in the City of Newark

Project No: 25-P-92358/02-02
Project Officer: Richard Bragg
Period: September 2004 to May 2007
Funding: $231,386
Principal Investigator: Ana Natale-Pereira
Award: Grant
Awardee: UMDNJ New Jersey Medical School
150 Bergen Street
Newark, NJ 07101

Status: This project is under the Hispanic Health Services Research Grant Program. The project is completed.

Description: Despite access to health care, screening for colorectal cancer remains low, particularly among Hispanics, due to several factors. Of those, lack of knowledge about the disease and screening recommendations by health care providers are significant barriers to screening. Other factors such as low literacy, socioeconomic status, and limited English proficiency have been linked to poor cancer outcomes.

This educational intervention study will: (1) assess CRC knowledge among the older minority population and community leaders of Newark, (2) develop a comprehensive CRC education module to educate community leaders using the educational sessions of workshops model; and (3) train the community leaders to use the CRC educational module as a tool to facilitate the dissemination of CRC information, enhance awareness and education, and increase screening rates. ■

Assessment of the U.S. Drug Safety System

Project No: HHSM-500-2005-00026C
Project Officer: Fatima Millar
Period: September 2005 to February 2007
Funding: $400,000
Award: Contract
Awardee: National Academy of Sciences, Institute of Medicine
2101 Constitution Ave, NW
Washington, DC 20418

Status: CMS staff met with IOM staff and the Committee Chair per their request for CMS to address questions about CMS's role in U.S. Drug Safety. IOM Committee drug safety meetings were scheduled and several committee members and staff conducted dissemination activities. A pre-publication manuscript went through the publication process and a report was disseminated to the public.

More information can be found at http://www.iom.edu/CMS/3793/26341.aspx.

Description: The contractor completed a report assessing the current system for evaluating and ensuring drug safety post-marketing and make recommendations to improve risk assessment surveillance, and the safe use of drugs in accordance with Section C. CMS is providing partial funding for this effort. Total estimated cost of the contract is $1,354,656. ■

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 2007
Funding: $5,075,408
Principal Investigator: Korbin Liu
Award: Task Order (RADSTO)
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

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. The contract has ended.

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. ■

Background Check Pilot Program

Project No: 500-00-0019/01
Project Officer: Kathryn Linstromberg
Period: September 2004 to September 2007
Funding: $3,024,408
Principal Investigator: Joyce McMahon
Award: Task Order (RADSTO)
Awardee: C.N.A. Corporation
4825 Mark Center Drive
Alexandria, VA 22311-1850

Status: The pilot States provided data to CMS on the efficacy of their programs. The contract ended in September 2007. It was modified several times the past year to include $718,401 to the funding.

Description: This request for proposal is to assist States and CMS by providing direct technical assistance to the States that are selected to participate in a statutorily mandated 3-year Background Check Pilot Program. The participating States are responsible for implementing State programs that require the conducting of comprehensive background checks of prospective direct access employees of long-term care facilities and providers. ■

BadgerCare Demonstration

Project No: 11-W-00125/05
Project Officer: Wanda Pigatt-canty
Period: January 1999 to March 2010
Funding: $0
Principal Investigator: Jason Helgerson
Award: Demonstration
Awardee: Wisconsin Department of Health and Family Services
One West Wilson Street, PO Box 309
Madison, WI 53701

Status: On May 30, 2007, a extension was granted for the Demonstration through March 31, 2010. In August 2007, the State submitted both Medicaid and SCHIP state plan amendments to facilitate the development of BadgerCare Plus. Both state plan amendments were approved in November 2007.

Description: BadgerCare was created as a health insurance program for low-income working families with children. BadgerCare is intended to provide health care coverage to families with incomes too high for Medicaid and who do not have access to affordable health insurance. By extending health care coverage to uninsured low-income families, BadgerCare originally sought to provide a safeguard against increasing the number of uninsured families and children as a result of Wisconsin's welfare reform program. BadgerCare is designed to bridge the gap between low-income Medicaid coverage and employer-provided health care coverage. The BadgerCare demonstration is funded by both Medicaid and SCHIP funds. The demonstration eligibles include: children to age 19 years with income of 100-200 % of the FPL (title XXI funded) , parents with income up to 130 % of the FPL (title XIX funded) and parents with income from 130% up to 200% of the FPL (title XXI funded). Demonstration eligibles receive the full Medicaid benefit package. In addition, the State can elect to pay premiums for employer sponsored health plans for BadgerCare eligibles if the cost less than enrollment into the BadgerCare program. ■

Basic Medicaid for Able-Bodied Adults

Project No: 11-W-00181/08
Project Officer: Kelly Heilman
Period: January 2004 to January 2009
Funding: $0
Principal Investigator: John Chappuis
Award: Waiver-Only Project
Awardee: Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604-4210

Status: As of July 31, 2007, 8,043 individuals were enrolled in the demonstration.

Description: The Montana statewide demonstration, "Montana Basic Medicaid for Able-bodied Adults," is approved for a five year period of February 1, 2004 through January 31, 2009. Under the Demonstration, optional Medicaid State Plan services are reduced for the mandatory State plan population of parents and other caretaker relatives, eligible under Sections 1925 or 1931 of the Social Security Act. Services are rendered on a fee-for-service basis, and cost-sharing is the same as under the State plan. This Demonstration allows Montana to continue offering the more limited benefit package that was approved as part of their welfare reform waiver, which expired on January 31, 2004. ■

Best Practices for Enrolling Low-Income Beneficiaries into the Medicare Prescription Drug Benefit Program

Project No: 500-00-0033/10
Project Officer: Noemi Rudolph
Period: September 2005 to September 2008
Funding: $1,530,214
Principal Investigator: Leslie Foster
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The First Annual Report was submitted to CMS in February 2007 that discussed the findings from a state survey and the first round of stakeholder interviews and focus groups. A second round of stakeholder interviews and focus groups was conducted in Summer 2007. Case study site visits were completed in Fall 2007 and a case study report has been submitted to CMS.

Description: The purpose of this task order is to design and conduct an analysis to identify the best practices of successfully enrolling low-income beneficiaries into the Medicare Drug Coverage Program. The findings from the study will be used to prepare a Report to Congress. The contractor will conduct analyses of primary data collected via interviews, focus groups, surveys, and case studies and an analysis of secondary data to determine take-up and enrollment rates using CMS data and other databases containing socio-economic data by geographic area. ■

Cancer Diagnosis and Treatment Among Medicare Managed Care Enrollees

Project No: ORDI-06-100106
Project Officer: Gerald Riley
Period: October 2006 to April 2008
Funding: $0
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: Analytic files have been created and analyses are proceeding.

Description: There is considerable policy interest in comparing patterns of care provided in the managed care and fee-for-service (FFS) sectors. Previous research has shown that patterns of cancer diagnosis and treatment often vary between the managed care and fee-for-service (FFS) sectors within the Medicare program. This study updates and extends earlier work using the Surveillance, Epidemiology, and End Results (SEER)-Medicare linked database, which combines tumor registry data with Medicare enrollment and claims data. The study covers the years 1998-2002 and includes elderly Medicare beneficiaries diagnosed with breast, prostate, and colorectal cancer. The analysis focuses on percents of cases diagnosed at early and late stages and, among early stage cases, managed care-FFS differences in treatment patterns. Plan variation in diagnosis and treatment patterns will be addressed. ■

Case-Mix Adjustment for Patients Using Swing Beds at Hospitals Participating in the Rural Community Hospital Demonstration

Project No: HHSM-500-2007-00022C
Project Officer: Siddhartha Mazumdar
Period: August 2007 to August 2011
Funding: $29,400
Principal Investigator: David Malitz
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

Status: Stepwise Systems, Inc. is performing the technical analysis for this project.

Description: This contract will implement a method of case-mix adjustment for patients using swing beds at hospitals participating in the Rural Community Hospital Demonstration. The policy of an adjustment according to the severity in patients' conditions was incorporateed into the demonstration in an effort to make the payment methodology more equitable to participating hospitals. ■

Childless Adults Aged 50-64

Project No: 11-W-00139/03
Project Officer: Camille Dobson
Period: March 2002 to January 2008
Funding: $0
Principal Investigator: Robert Maruca
Award: Waiver-Only Project
Awardee: District of Columbia, Department of Health
825 N. Capitol St, NE
Washington, DC 20012

Status: This demonstration expires on January 31, 2008. The District of Columbia has submitted a request for extension for an additional three years. The request is currently under review.

Description: This demonstration extends coverage to childless adults age 50-64 with incomes up to 50 percent FPL. They receive full Medicaid benefits delivered through managed care organizations. The demonstration is funded by diverted DSH funding of $12.9 million annually. ■

Chiropractor Demonstration

Project No: ORDI-05-0006
Project Officer: Claudia Lamm
Period: April 2005 to March 2007
Funding: $0
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The demonstration began on April 1, 2005, and ended on March 31, 2007.

Description: The Centers for Medicare and Medicaid Services (CMS) will conduct a demonstration to expand coverage of chiropractic services in the State of Maine (rural); New Mexico (rural HPSA); 26 counties in Northern Illinois and Scott County Iowa (urban); and 17 central counties in Virginia (urban HPSA). The demonstration began in April 2005 and will operate for two years.

Any chiropractor that provides services in these geographic areas will be able to participate in the demonstration. Any beneficiary enrolled under Medicare Part B, and served by chiropractors practicing in these sites would be eligible to receive services. Physician approval would not be required for these services. The statute requires that the demonstration be budget neutral. ■

Chronically Ill Disease Research Data Warehouse (723 Database) - Phase II

Project No: HHSM-500-2005-00182G
Project Officer: Spike Duzor
Period: September 2005 to September 2008
Funding: $7,981,604
Award: GSA Order
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway
West Des Moines, IA 50266

Status: The contract has been modified to authorize the purchase of two server bundles and applicable Oracle

licensing. It was modified to exercise Options I and II and was extended to September 2008. This additional equipment will house Part D drug event data.

Description: This contractor will operate the section 723 warehouse and develop a process to disseminate data to health services researchers studying ways to improve the quality and reduce the cost of care provided to chronically ill Medicare beneficiaries. Additionally this contract expands the sample of beneficiaries and data elements to be included in the data warehouse. This contract option will permit researchers to link, at the person level, Medicare claims with Part D drug event data. ■

Chronically Ill Medicare Beneficiary Research, Data, and Demonstration

Project No: 500-00-0031/04
Project Officer: Linh Phuong
Period: November 2004 to December 2006
Funding: $789,621
Principal Investigator: Christopher Tompkins
Dan Gilden
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Brandeis/JEN delivered the final reports for their evaluation on December 29, 2006. The project has ended and the contract has been closed out.

Description: This project is in support of Section 723 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Brandeis/JEN will evaluate the current Enterprise Cross Reference (ECR) and Medicare, Medicaid, and Assessment link keys developed by OIS. They will provide recommendations on the OIS link-key process and confidence score weights by defining how specific data elements should be considered when matching records both within State and across State matching. ■

Clilnical Logic of Episode Groupers

Project No: HHSM-500-2006-00008I/02
Project Officer: Fred Thomas
Period: August 2007 to August 2008
Funding: $499,503
Principal Investigator: David Kennell
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project is underway.

Description: Under another CMS contract, Acumen LLC, is evaluating the basic functionality and application of two episode groupers. Medstat (MEG) and Ingenix/ Symmetry (ETG), using Medicare claims data from four states. Under this task order, the clinical integrity of these groupers will be studied and reviewed with expert panels of physicians. Products will include a report on impacts of the use of groupers on physician pay-for-performance initiatives. ■

Comprehensive HIV/AIDS Treatment

Project No: 18-P-93110/6-01
Project Officer: Joseph Razes
Period: June 2005 to December 2006
Funding: $337,280
Principal Investigator: George Smith
Award: Grant
Awardee: Donald R. Watkins Memorial Foundation
4900 Fannin Street
Houston,TX 77004

Status: The project is complete.

Description: The objective of this project is to provide HIV-positive patients in Harris County with state of the art outpatient healthcare services; "on-call" HIV emergency care 24 hours a day, seven days per week; and comprehensive, holistic healthcare that addresses all of their HIV-related health concerns, including a variety

of support services to be accessed with primary medical care. ■

Consumer-Directed Chronic Outpatient Services Demonstration

Project No: ORDI-05-0007
Project Officer: Claudia Lamm
Pauline Lapin
Period: January 2005 to
January 2009
Funding: $0
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: CMS and its co-sponsoring organization, ASPE, have been conducting ongoing meetings with the demonstration design contractors, Medstat and Abt Associates. The contractors have delivered a best practices report and a technical advisory group has been identified and met on April 5, 2005. The TAG made recommendations to our contractors on the demonstration's target population and site selection. Internal meetings continue to be held to discuss demonstration design options.

A Technical Advisory Group, convened to consider the demonstration design,was skeptical about its feasibility. CMS and its partner in the demonstration, ASPE approached potential sites with the infrastructure needed to implement the proposed model; there was only one potential participant. However, they offered a potential pool of only 40 Medicare beneficiaries who would meet the demonstration criteria. Therefore, CMS and ASPE concluded that it was not feasible to implement the demonstration.

Description: This demonstration will evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and that reduce Medicare expenditures, including methods to permit Medicare beneficiaries to direct their own health care needs and services. Prior to initiation of these demonstrations, the Secretary is required to evaluate best practices used by group health plans, State Medicaid Programs, the private sector or other areas for methods that allow patients to self-direct the provision of personal care services. The Secretary is required to initiate these demonstrations not later than two years after enactment, and Reports to Congress are required beginning two years after projects begin. The Secretary is required to evaluate clinical and cost-effectiveness of the demonstrations. The Centers for Medicare and Medicaid Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE) are jointly designing this demonstration. ■

Contractor Support for the Development of a Waiver Cost Estimate for the Electronic Health Record Demonstration

Project No: HHSM-500-2006-00005I/05
Project Officer: Debbie Vanhoven
Period: September 2007 to
September 2008
Funding: $123,276
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale,VA 22003

Status: A contract was awarded to Actuarial Research Corporation on September 21, 2007. A kick-off meeting was convened on October 10, 2007 and the contractor has initiated work on the development of a draft waiver cost estimate package to be submitted for CMS review.

Description: The Centers for Medicare and Medicaid Services (CMS) plans to implement a demonstration project in up to 12 states that aims to promote high-quality care through the adoption and use of electronic health records in select physician practices. This Task Order allows an independent contractor to assist CMS in the development of this demonstration by preparing waiver cost estimate documentation for submission to the Office of Management and Budget (OMB) for approval. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Arizona

Project No: 95-C-91318/09
Project Officer: Ronald Lambert
Period: August 2002 to July 2008
Funding: $0
Principal Investigator: Beth Hale
Award: Cooperative Agreement
Awardee: Hospice of the Valley
3238 North 16th Street
Phoenix, AZ 85016

Status: Hospice of the Valley is offering an urban case management program to Medicare beneficiaries in Maricopa County, Arizona, with significant chronic illness. Targeting beneficiaries with various chronic conditions, the program focuses on providing and coordinating chronic and palliative care. The site began enrolling beneficiaries and providing coordinated care services in August 2002.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Houston, Texas

Project No: 95-C-91351/05
Project Officer: John Pilotte
Period: June 2002 to May 2008
Funding: $82,350
Principal Investigator: Ken Yale
Award: Cooperative Agreement
Awardee: CorSolutions Medical, Inc.
9500 W. Bryn Mawr Avenue
Rosemont, IL 60018

Status: The disease management program targets beneficiaries in the Greater Houston, Texas Metropolitan Area with high-risk congestive heart failure. The site is currently providing coordinated care services.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project allows CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Iowa

Project No: 95-C-91340/07
Project Officer: Siddhartha Mazumdar
Period: April 2002 to March 2008
Funding: $50,000
Principal Investigator: Nancy Halford
Award: Cooperative Agreement

Awardee: Mercy Medical Center - North Iowa
1000 N. Fourth Street, NW
Mason City, IA 50401

Status: Mercy Medical Center of Mason City, Iowa, has implemented a rural case management program targeting beneficiaries in northern Iowa with various chronic conditions. The site is currently enrolling beneficiaries and providing coordinated care services.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Mahomet, Illinois

Project No: 95-C-91315/5
Project Officer: Dennis Nugent
Period: April 2002 to March 2008
Funding: $149,943
Principal Investigator: Cheryl Schraeder
Award: Cooperative Agreement
Awardee: Carle Foundation Hospital
307 East Oak #3, PO Box 718
Mahomet, IL 61853

Status: The Carle Foundation Hospital of Mahomet, Illinois, has implemented a rural case management program targeting beneficiaries with various chronic conditions in eastern Illinois. The is currently enrolling beneficiaries and providing coordinated care services.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Maine

Project No: 95-C-91314/01
Project Officer: Siddhartha Mazumdar
Period: April 2002 to March 2008
Funding: $138,720
Principal Investigator: John LaCasse
Award: Cooperative Agreement
Awardee: Medical Care Development
11 Parkwood Drive
Augusta, ME 04330

Status: Medical Care Development of Augusta, Maine, has implemented a rural disease management program targeting beneficiaries in Maine with congestive heart failure or post-acute myocardial infarction. The site is currently providing coordinated care services.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing

quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Missouri

Project No: 95-C-91345/7
Project Officer: Ronald Lambert
Period: August 2002 to July 2008
Funding: $150,000
Principal Investigator: John Lynch
Award: Cooperative Ageement
Awardee: Washington University Physician Network
660 South Euclid Avenue, Campus Box 8066
St. Louis, MO 63110

Status: Washington University of St. Louis, Missouri, has implemented an urban case management program targeting beneficiaries in St. Louis with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in August 2002.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - New York, New York

Project No: 95-C-91357/2
Project Officer: Dennis Nugent
Period: June 2002 to May 2008
Funding: $150,000
Principal Investigator: Patricia Mulvey
Award: Cooperative Ageement
Awardee: The Jewish Home and Hospital for the Aged
120 West 106th Street
New York, NY 10025

Status: The Jewish Home and Hospital for the Aged has implemented an urban case management program targeting beneficiaries with various chronic conditions in New York City. The site is currently enrolling beneficiaries and providing coordinated care services.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Northern California

Project No: 95-C-91352/02
Project Officer: John Pilotte
Cynthia Mason
Period: July 2002 to
June 2008
Funding: $150,000
Principal Investigator: Jane Murray
Award: Cooperative Ageement
Awardee: QMED
25 Christopher Way
Eatontown, NJ 07724

Status: QMED, Inc., Eatontown, New Jersey, has implemented a disease management program targeting beneficiaries in northern California with coronary artery disease.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Pennsylvania

Project No: 95-C-91360/03
Project Officer: Cynthia Mason
Period: April 2002 to
March 2008
Funding: $0
Principal Investigator: Kenneth Coburn
Award: Cooperative Ageement
Awardee: Health Quality Partners
875 N. Easton Road
Doylestown, PA 18901

Status: Health Quality Partners of Doylestown, Pennsylvania, has implemented an urban and rural disease management program targeting beneficiaries in eastern Pennsylvania with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in April 2002. It is now in it's sixth year of service.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - Richmond, Virginia

Project No: 95-C-91319/03
Project Officer: Cynthia Mason
Period: April 2002 to March 2008
Funding: $75,448
Principal Investigator: Michael Matthews
Award: Cooperative Ageement
Awardee: CenVaNet
2201 W. Broad Street, Suite 202
Richmond,VA 23220

Status: CenVaNet, Incorporated of Richmond, Virginia, has implemented an urban case management program targeting beneficiaries with various chronic conditions in the metropolitan Richmond area. The site began enrolling beneficiaries and providing coordinated care services in April 2002. It is now in it's 6th year of service.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries - South Dakota

Project No: 95-C-91362/08
Project Officer: Siddhartha Mazumdar
Period: June 2002 to May 2008
Funding: $0
Principal Investigator: David Kuper
Award: Cooperative Ageement
Awardee: Avera McKennan Hospital
800 East 21st St
Sioux Falls, SD 57105

Status: Avera McKennan Hospital of Sioux Falls, South Dakota, has implemented a rural disease management program targeting beneficiaries in South Dakota, Iowa, and Minnesota.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

Cost-Effective and Scalable Strategies for Enrolling Medicare Beneficiaries in Medicare Prescription Drug Extra Help

Project No: 1R0CMS300065
Project Officer: Susie Butler
Period: March 2006 to February 2010
Funding: $156,200
Principal Investigator: Kristen Keifer
Award: Grant
Awardee: National Council on the Aging
300 D St, NW
Washington, DC 20024

Status: The Grant was awarded and work has begun. The first interventions were evaluated and the second phase of interventions is beginning.

Description: NCOA proposes to use public-private partnerships to support strategies for identifying and enrolling eligible beneficiaries using tailored, list-driven intervention approaches already known to be effective in Low Income Subsidy (LIS) enrollment. Private funds will be used to award in grants to support test interventions. NCOA plans to test 8-9 interventions per year. CMS will support NCOA efforts by refining marketing lists. This will allow the "cleanest" list possible of potential LIS-eligibles. Use of similarly refined lists for outreach to low income populations has been shown to increase the enrollment success rate. CMS grant funding will be used evaluate list-based outreach strategies. NCOA plans to partner with L&M Policy Research to evaluate the intervention approaches. ■

Cost Effectiveness Model of Disease Modifying Therapies for the Treatment of Multiple Sclerosis (MS), A

Project No: CMS-IA-05-28A-1
Project Officer: Penny Mohr
Period: October 2004 to October 2006
Funding: $95,693
Principal Investigator: Paul Tappenden , Ph.D.
Award: Intra-agency Agreement
Awardee: Sheffield University School of Health and Related Research
Regent Court 30, Regent Street
Sheffield, UK S1 4DA

Status: A final report was completed in October 2006 is available through the CMS project officer. Contact Penny Mohr at 410-786-6502.

Description: The purpose of this task order is to examine the incremental cost-effectiveness of self-administered medications (Copaxone, Betaseron, Rebif) relative to Avonex or best supportive care for the treatment of Multiple Sclerosis (MS) among Medicare beneficiaries. The self-administered medications listed are covered under a Medicare demonstration program mandated by Section 641 of the Medicare Prescription Drug Improvement and Modernization Act (MMA). Avonex is currently covered under Medicare Part B. An analysis of the cost-effectiveness of the demonstration project that extends coverage to these therapies is required under the MMA. ■

Cost-Effectiveness of Daily versus Conventional Hemodialysis for the Medicare Population, The

Project No: ORDI-05-0009
Project Officer: Penny Mohr
Period: December 2003 to June 2010
Funding: $0
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The research protocol has been completed, which includes a plan for analyzing the cost-effectiveness of more frequent hemodialysis to the Medicare Program. Randomization of study subjects have begun. Study results are expected to be available by June 2010. More information on the trials can be found at: http://www.niddk.nih.gov/patient/hemodialysis/hemodialysis.htm.

Description: CMS is jointly sponsoring two clinical trials with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) on daily hemodialysis. The purpose of these trials is to understand the clinical, quality of life, and economic effects of more frequent hemodialysis. The two trials compare conventional hemodialysis to two different forms of daily hemodialysis: short, in-center hemodialysis performed six times weekly and nocturnal hemodialysis – where a patient dialyzes at night at home while they sleep. A representative from ORDI assisting in the development of cost data collection design, collection, and analysis. Results from the cost study may be used to inform how

Medicare might pay for more frequent hemodialysis if the technique proves to have significant health benefits for Medicare beneficiaries. ■

Cost-Effectiveness of Early Preventive Care for Children in Medicaid

Project No: ORDI-IM-084
Project Officer: Paul Boben
Period: June 2000 to December 2009
Funding: $0
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The project is ongoing.

Description: This project will feature a cost-benefit analysis of primary and preventive care for children up to age 2. Medicaid claims data from the State Medicaid Research Files data base will be used to compare costs of care for children receiving the recommended battery of well-child visits versus those that do not. The benchmark for standard care will be the American Academy of Pediatrics' (AAP) recommended series of well-baby visits and immunizations. This study follows work by Hakim and Bye (Pediatrics, forthcoming) that showed an association between compliance with the AAP schedule and reduced risk of avoidable hospitalization. ■

Cost Effectiveness of Etanercept, Adalimumab and Anakinra in Comparison to Infliximab in the Treatment of Patients with Rheumatoid Arthritis in the Medicare Program, The

Project No: CMS-IA-05-28A-2
Project Officer: Penny Mohr
Period: October 2004 to October 2006
Funding: $99,592
Principal Investigator: Allan Wailloo, Ph.D
Award: Intra-agency Agreement
Awardee: Sheffield University School of Health and Related Research
Regent Court 30, Regent Street
Sheffield, UK S1 4DA

Status: A final report was completed October 12, 2006 and can be obtained by contacting the government project officer, Penny Mohr, at penny.mohr@cms.hhs.gov or 410-786-6502.

Description: This study examines the incremental cost-effectiveness of the self-administered immuno-modulating drugs etanercept, adalimumab, and anakinra, which are covered under a Medicare demonstration program mandated by Section 641 of the Medicare Prescription Drug Improvement and Modernization Act – relative to that of physician-administered infliximab, which is currently covered under Medicare Part B. An analysis of the cost-effectiveness of the demonstration project that extends coverage to these therapies is required under the Prescription Drug Improvement and Medicare Modernization Act. ■

Creation of New Race-Ethnicity Codes and Socioeconomic Status (SES) Indicators for Medicare Beneficiaries

Project No: 500-00-0024/21
Project Officer: Barbara Cohen
Period: August 2005 to July 2007
Funding: $197,318
Principal Investigator: Arthur Bonito
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The project is complete.

Description: This project once again created the improved race-ethnicity codes using the most current 10 segments of the unloaded Enrollment Database (EDB) as well as the geocodes for linking specific SES indicators for Medicare beneficiaries' residential areas. This logical follow-on to the original work re-ran the already developed algorithms to create new race-ethnicity codes and block group Federal Information Processing Standard (FIPS) geocodes to link Census SES measures for new enrollees in the EDB since the original work was completed.

The updated file(s) will then be used to populate a data mart with the improved race-ethnicity codes and block group FIPS geocode to link SES measures. This data

mart will be used by the regions to better target outreach and educational activities towards beneficiaries. The basic elements of the data mart will include demographic variables (age, race-ethnicity), type of coverage, health status, and SES. The latter element is extremely vital for efforts to enroll beneficiaries into the Low Income Subsidy. ■

Data Collection for the Second Generation S/HMO Demonstration

Project No: 500-01-0025/03
Project Officer: Dennis Nugent
Period: September 2004 to September 2008
Funding: $3,224,421
Principal Investigator: Todd Ensor
Award: Task Order (ADDSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The project data collection work is continuing. Option year three was deleted from the contract.

Description: CMS(Formerly HCFA)has been conducting the Social Health Maintenance Organization(S/HMO)Demonstration since 1985. It was implemented in response to section 2355 of Public Law 98-369 (the Deficit Reduction Act of 1984) which authorized the Secretary of DHHS to approve applications and protocols submitted to waive certain requirements of title XVIII and title XIX of the Social Security Act to demonstrate the concept of a social HMO.

This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization(S/HMO-II)Demonstration which began in 1996. The work was done by Mathematica Policy Research under a subcontract until Fall 2004. However, Mathematica is now conducting this data collection work under its own contract. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. (A sampling method is used now.) The information gathered served three primary functions: baseline and follow-up data for the analyses; clinical information to the participating S/HMO-II site for care planning; and data for risk-adjustment and payment. ■

Demonstration of HHA Settlement for Dual Eligibles for the State of Connecticut.

Project No: 95-W-00086/01
Project Officer: Juliana Tiongson
Period: January 2001 to December 2011
Funding: $0
Principal Investigator: Kristine Ragaglia
Award: Waiver-Only Project
Awardee: Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Status: A three level series of appeals has been developed for this project. The first level is a reconsideration review by the demonstration RHHI, National Government Services. If the State is dissatisfied with a reconsideration determination, a State official will submit the sample claim(s) in question for review along with a rationale to a CMS official. If such CMS officials cannot resolve the matter with the State, CMS shall submit the case to an outside arbitrator. Arbitration will be the final step in resolving the cases.

Description: CMS is conducting a pilot program with the States of Connecticut, Massachusetts, and New York that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were originally submitted to and paid by the Medicaid agencies. This sampling will be used in lieu of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This process will eliminate the need for the home health agencies (HHA) to assemble, copy, and submit huge numbers of medical records, as well as the need for the regional home health intermediary (RHHI) to review every case.

The demonstration will consist of two components: (1) an educational initiative to improve the ability of all parties to make appropriate coverage recommendations for crossover claims and (2) a statistically valid sampling methodology to be applied in settlement of claims paid by Medicaid for which the State believes may have potential to also be covered by Medicare.

The demonstration in Connecticut covers HHA claims for Fiscal Years 2001 through 2007. The initial reviews have been conducted on the Fiscal Year 2001 and Fiscal Year 2003 claims for Connecticut and initial payments have been made for these years. ■

Demonstration of Home Health Agencies Settlement for Dual Eligibles for the State of New York

Project No: 95-W-00084/02
Project Officer: Juliana Tiongson
Period: January 2002 to December 2011
Funding: $0
Principal Investigator: Jeff Flora
Award: Waiver-Only Project
Awardee: Office of Medicaid Management, New York Department of Health, Empire State Plaza Corning Tower, Room 1466 Albany, NY 12237

Status: The demonstration in New York covers the Fiscal Years 2000 through 2007. Initial reviews have been conducted on the 2000, 2001, and 2002 claims for New York and initial payments have been made for these years. A three-level series of appeals has been developed for this project. The first level is a reconsideration review by the demonstration RHHI, Associated Hospital Service. If the State is dissatisfied with a reconsideration determination, a State official will submit the sample claim(s) in question for review along with a rationale to a CMS official. If such CMS officials cannot resolve the matter with the State, CMS shall submit the case to an outside arbitrator. Arbitration will be the final step in resolving the cases. Initial reviews have been conducted on the Fiscal Year 2001 claims for Connecticut and Massachusetts and payments have been made to these States. The demonstration RHHI, National Government Services, is currently reviewing the Fiscal Year 2001 claims for New York. A reconsideration process has been finalized and framework has been developed for the educational component. Arbitration will occur beginning in April 2008 on those cases appealed by the State of New York.

Description: CMS is conducting a pilot program with the States of Connecticut, Massachusetts, and New York that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dually eligible beneficiaries that were originally submitted to and paid by the Medicaid agencies. This sampling will be used in lieu of individually gathering Medicare claims from home health agencies for every dually eligible Medicaid claim the State has possibly paid in error. This process will eliminate the need for the home health agencies (HHA) to assemble, copy, and submit huge numbers of medical records, as well as the need for the regional home health intermediary (RHHI) to review every case.

The demonstration consists of two components: (1) an educational initiative to improve the ability of all parties to make appropriate coverage recommendations for crossover claims and (2) a statistically valid sampling methodology to be applied in settlement of claims paid by Medicaid for which the State believes may have a potential to also be covered by Medicare. ■

Demonstration to Improve Direct Service Community Workforce

Project No: 95-P-92214/04-01
Project Officer: Kathryn King
Period: September 2003 to September 2007
Funding: $1,403
Principal Investigator: Roy Burnette
Linda Kendall-Fields
Award: Grant
Awardee: Pathways for the Future, Inc.
525 Mineral Springs Drive
Sylva, NC 28779

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: The Demonstration to Improve the Direct Service Community Workforce grant initiative is part of the President's New Freedom Initiative to eliminate barriers to equality and grant a "New Freedom" to children and adults of all ages who have a disability or long-term illness so that they may live and prosper in their communities. CMS awarded five demonstration grants, which run from September 30, 2003 to September 29, 2006, to assist States and others to develop innovative programs and strategies that improve recruitment, and the retentions of direct service workers. ■

Demonstration to Improve Direct Service Community Workforce

Project No: 95-P-92168/03-01
Project Officer: Kathryn King
Period: September 2003 to September 2007
Funding: $680,500
Principal Investigator: Mark Bernstein
Award: Grant
Awardee: University of Delaware
College of Human Services/EPP/CDS, New Castle County
Newark, DE 19716

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: The Demonstration to Improve the Direct Service Community Workforce grant initiative is part of the President's New Freedom Initiative to eliminate barriers to equality and grant a "New Freedom" to children and adults of all ages who have a disability or long-term illness so that they may live and prosper in their communities. CMS awarded five demonstration grants, which run from September 30, 2003 to September 29, 2006, to assist States and others to develop innovative programs and strategies that improve recruitment, and the retentions of direct service workers. ■

Demonstration to Improve Direct Service Community Workforce

Project No: 95-P-92225/03-01
Project Officer: Kathryn King
Period: September 2003 to September 2007
Funding: $680,500
Principal Investigator: Angela King
Award: Grant
Awardee: Volunteers of America, Inc.
National Office, 1660 Duke Street
Alexandria, VA 22314

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: The Demonstration to Improve the Direct Service Community Workforce grant initiative is part of the President's New Freedom Initiative to eliminate barriers to equality and grant a "New Freedom" to children and adults of all ages who have a disability or long-term illness so that they may live and prosper in their communities. CMS awarded five demonstration grants, which run from September 30, 2003 to September 29, 2006, to assist States and others to develop innovative programs and strategies that improve recruitment, and the retentions of direct service workers. ■

Demonstration to Improve Direct Service Community Workforce

Project No: 11-P-92187/01-01
Project Officer: Kathryn King
Period: September 2003 to September 2007
Funding: $1,403,000
Principal Investigator: Elise Scala
Award: Grant
Awardee: State of Maine/Governor's Office of Health Policy & Finance,
#1 State House Station
Augusta, ME 04333-0001

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: The Demonstration to Improve the Direct Service Community Workforce grant initiative is part of the President's New Freedom Initiative to eliminate barriers to equality and grant a "New Freedom" to children and adults of all ages who have a disability or long-term illness so that they may live and prosper in their communities. CMS awarded five demonstration grants, which run from September 30, 2003 to September 29, 2006, to assist States and others to develop innovative programs and strategies that improve recruitment, and the retentions of direct service workers. ■

Demonstration to Improve the Direct Service Community Workforce

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

Status: The grantee implemented its interventions. The grant was extended to September 31, 2007 and is now complete.

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. ■

Demonstration to Improve the Direct Service Community Workforce

Project No: 11-P-92247/05-01
Project Officer: Kathryn King
Period: May 2004 to September 2007
Funding: $1,403,000
Principal Investigator: Kris Prohl
Award: Grant
Awardee: BRIDGES, Inc.
2650 West 35th Avenue
Gary, IN 46408

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: This grantee will recruit and retain DSWs by providing access to cafeteria benefits, an in-house career ladder, and a travel allowance. The grantee will also develop and promote a mentorship program and bonus pay incentives. ■

Demonstration to Improve the Direct Service Community Workforce

Project No: 11-P-92175/06-01
Project Officer: Kathryn King
Period: May 2004 to September 2007
Funding: $680,000
Principal Investigator: Herb Sanderson
Award: Grant
Awardee: Arkansas, Department of Health and Human Services
Division of Medical Services
PO Box 1437, Slot S401
Little Rock, AR 72203-1437

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: This grantee will recruit and retain DSWs by providing access to cafeteria benefits, an in-house career ladder, and a travel allowance. The grantee will also develop and promote a mentorship program and bonus pay incentives. ■

Demonstration to Improve the Direct Service Community Workforce

Project No: 11-P-92212/03-01
Project Officer: Kathryn King
Period: May 2004 to September 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

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: This grantee will recruit and retain DSWs by providing access to cafeteria benefits, an in-house career ladder, and a travel allowance. The grantee will also develop and promote a mentorship program and bonus pay incentives. ■

Demonstration to Improve the Direct Service Community Workforce

Project No: 11-P-92243/00-01
Project Officer: Kathryn King
Period: May 2004 to September 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

Status: The grantee implemented its interventions. The grant was extended to September 27, 2007 and is now complete.

Description: This grantee will recruit and retain DSWs by providing access to cafeteria benefits, an in-house career ladder, and a travel allowance. The grantee will also develop and promote a mentorship program and bonus pay incentives. ■

Demonstration to Maintain Independence and Employment - District of Columbia

Project No: 11-P-91421/03
Project Officer: Claudia Brown
Stephen Hrybyk
Period: January 2002 to December 2008
Funding: $12,599,022
Principal Investigator: Robert Cosby, M.D.
Award: Grant
Awardee: District of Columbia, Department of Health, Medical Assistance Administration
Suite 5135, N. Capitol St., NE
Washington, DC 20002

Status: The program is operating at full capacity. The program will be granted a no cost extension to continue through CY 2008.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

The demonstration provides highly active antiretroviral drug therapy (HAART) to 420 persons who have early HIV infection, and are not yet disabled under SSA criteria. The demonstration also provides the full range of Medicaid benefits to participants. Persons being served are primarily African American (76 percent). Fifty-nine percent are between the ages of 25 and 44, while 37 percente are 45-64. The program has spent $4 million in service claims, at an average of $8,635 per enrollee. Eighty-three percent of the expenditures have been for prescription drugs. ■

Demonstration to Maintain Independence and Employment - Kansas

Project No: 11-P-92389/07-01
Project Officer: Stephen Hrybyk
Period: April 2006 to September 2009
Funding: $5,000,000
Principal Investigator: Mary Ellen O'Brien Wright
Award: Grant
Awardee: Kansas, Department of Social and Rehabilitation Services
915 Harrison St. 6th Floor North
Topeka, KS 66612-1570

Status: The program is in the second year of operation.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

This demonstration will provide State Medicaid and other health and employment support services as wraparound coverage to a targeted 200 people with health insurance through the Kansas high-risk pool, also known as the Kansas Health Insurance Association (KHIA). People in the high-risk pool experience multiple severe conditions for which they have been unable to obtain employer-sponsored coverage or reasonably priced private coverage. They are ineligible for either Medicaid

or Medicare and about one-third of participants are employed. The goals of the project are to improve the health and quality of life of individuals in the intervention group and to demonstrate that, compared to a carefully matched control group of 200 individuals also in the pool, they maintain a higher rate of employment and are less likely to become eligible for any form of Social Security disability benefits or other forms of public assistance. ■

Demonstration to Maintain Independence and Employment - Minnesota

Project No: 11-P-92387/05-01
Project Officer: Stephen Hrybyk
Period: November 2006 to September 2009
Funding: $5,000,000
Principal Investigator: MaryAlice Mowry
Award: Grant
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: The program is in the second year of operation.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

The Department of Human Services is using this demonstration as an opportunity to build on its history of creating public-private partnerships to better serve the needs of Minnesotans coping with mental illness. It serves a targeted 1,500 to 1,800 employed people diagnosed with serious mental illness in Hennepin, Ramsey, and St. Louis Counties. Employment-related services include ongoing contact with a project navigator, a peer support program, and employment counseling. Medical services and employment interventions will be delivered through a network of partnering health plans and community mental health service providers. ■

Demonstration to Maintain Independence and Employment - Rhode Island

Project No: 11-P-91174/01
Project Officer: Shawn Terrell
Period: October 2000 to December 2006
Funding: $500,000
Principal Investigator: Dianne Kayala
Award: Grant
Awardee: Rhode Island, Department of Human Services, HCQFP, Center for Adult Health
600 New London Avenue
Cranston, RI 02920

Status: The Rhode Island project was inactive due to fiscal barriers in securing the non-federal share of the service costs. This project never got started.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

The Rhode Island Project uses grant funding in conjunction with State funds to provide the full Medicaid benefit package, plus extra services such as targeted case management, personal assistance services, pharmaceutical co-payments, and other employment supports to individuals. ■

Demonstration to Maintain Independence and Employment - Texas

Project No: 11-P-91420/06
Project Officer: Shawn Terrell
Period: March 2007 to December 2009
Funding: $21,000,000
Principal Investigator: Dena Stoner
Award: Grant
Awardee: Texas, Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247

Status: Data is being collected, programs have started, and they are still recruiting. They are now at 60 percent of the projected recruiting levels and should be a full level by the end of March 2008.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

Texas proposed to redesign their project to use a public / private partnership in the provision of comprehensive behavioral health benefits to working adults at risk of becoming disabled in the Houston area. The insurance benefit will augment existing employer sponsored coverage and may provide full coverage for working individuals who do not have access to employer sponsored coverage (i.e. self-employed). It is anticipated that many people displaced by hurricane Katrina who are currently residing in the Houston area will take advantage of this program. ■

Demonstration-Based Review of Physician Practice Expense Geographic Adjustment Data

Project No: 500-00-0024/16
Project Officer: Jesse Levy
Period: July 2004 to March 2008
Funding: $613,917
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

Status: The report that led to the Report to Congress was delivered in March 2006. It is located here:

http://www.cms.hhs.gov/Reports/downloads/Pope03-06.pdf

The GPCI geographic configuration report is in process.

Description: This contract supported a Report to Congress.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. Work has also been performed supporting GPCI geographic configuration analysis. ■

Design and Implementation of a Beneficiary Survey on Access to Selected Prescription Drugs and Biologicals

Project No: 500-01-0025/02
Project Officer: Penny Mohr
Period: September 2004 to November 2006
Funding: $589,537
Principal Investigator: Arnold Chen
Award: Task Order (ADDSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: A report on the findings of the beneficiary survey was completed in February 2006 and is available on the CMS website. (Medicare Replacement Drug Demonstration Beneficiary Survey: Report of Findings

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA641_Beneficiary_Survey_Report.pdf)

The survey targeted 3,962 early participants in the Medicare Replacement Drug Demonstration and attained an 86 percent response rate. Participants served as their own controls and were asked about their perspectives on changes that were brought about through the demonstration program including: access to drug therapy; beneficiary financial and travel burden; perceived health status; satisfaction with medication costs and side effects; benefits intrinsic to the self-administration versus physician-administration of medications; and adherence to treatment regimen.

A report on outreach and enrollment efforts under the demonstration was completed in November 2006 and is available on the CMS website. (Study of Outreach and Enrollment Efforts for the Section 641 Medicare Replacement Drug Demonstration

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA641_Outreach_Enrollment_Report.pdf)

Description: The original intent of this project was to design and implement a survey of a sample of Medicare beneficiaries who participated in the Medicare Replacement Drug Demonstration. The demonstration, authorized under Section 641 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, provided coverage for selected self-administered prescription drugs and biologicals that replaced medications already covered under Medicare Part B. The project was later expanded to explore factors that contributed to lower enrollment and utilization of the benefit than was expected through key informant interviews. ■

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 December 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

Status: The project received OMB clearance to pilot test the assessment instrument. A final report was 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 was included. The contract has ended.

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

Development and Validation of MDS 3.0

Project No: 500-00-0027/02
Project Officer: Robert Connolly
Period: April 2003 to March 2008
Funding: $4,039,564
Principal Investigator: Debra Saliba
Award: Task Order (RADSTO)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: A competitive RADSTO award was made to RAND under the leadership of Deb Saliba, MD (from RAND and UCLA) and Joan Buchanan (from Harvard University Medical School). A contract modification was then made to RAND to extend the period of performance and to expand the number of States and size of the Natural MDS 3.0 Validation Sample. Another contract modification was made to RAND to extend to add resident assessment protocol development and consultation tasks and to provide consultation on CMS's plan to develop an integrated post acute care instrument. In July of 2007, the period of performance for this task order was extended from December 31, 2007 to March 31, 2008. The additional time will allow CMS and RAND additional time to analyze data and decide on MDS 3.0 implementation changes based on onsite validation activities in eight (8) States and seventy (70) nursing homes.

Description: The purpose of this procurement is to refine and validate Version 3.0 of the MDS. The goal of the refinement is to produce a valid instrument that reduces user burden; is more clinically relevant, while still achieving the federal payment mandates and quality initiatives; is more intuitive for users; includes better use of standard assessment scales; use of common language from health information and HIPPA standards; assesses resident quality of life; and, where possible, is more resident-centered.

Prior to drafting MDS 3.0, CMS convened a number of clinical meetings with industry experts to identify

existing scales, indices, and measurement tools that are relevant to the nursing home setting. Information obtained by the clinical meetings will be shared with the offeror to help create a revised MDS tool. The goal is to create an instrument which is fluid and can adapt to various resident populations without being redundant or burdensome to facilities specializing in specific populations.

Guidelines for each item must be developed that clarify the intent, definition, and process for collecting and coding for each data item. This material must be suitable for software with wizards and other intuitive data accumulation methods. Providers and stakeholders must be involved throughout the refinement and validation process. In addition, for each data item considered for the MDS 3.0, the specific uses of the element must be identified resource utilization group item, quality measure, quality indicator, resident assessment protocols (RAP), etc. as well as specifying implications of any revised item to the RAPs, the Prospective Payment System (PPS), and State-specific case mix systems. Special attention should also be paid to how the instrument can be modified to suit a quarterly assessment form and how the final instrument fits with the Medicare Payment Assessment Form (MPAF).

Payment items considered for revision cannot be changed unless a direct crosswalk between the revised item and the old payment item is available and must be validated in the field testing of the instrument. The offeror will take this information into consideration when redesigning the tool.

In designing the analytic plan and implementing the validation study, it was recommended that the contractor work with an organization knowledgeable about the MDS instrument, its history and current uses. The contractor is working with the State Quality Improvement Organizations to recruit nurses within each state to conduct the onsite validation and information collection. This approach was particularly effective in minimizing travel expenditures and expediting the onsite data collection. CMS recognizes that this is only one approach and is just discussed as one possible option in conducting the validation. Other options are also welcome but should be described in detail as part of the work plan. ■

Development of a National MAX Enrollee File

Project No: 500-02-0006/06
Project Officer: David Baugh
Period: September 2005 to June 2008
Funding: $109,981
Principal Investigator: Celia H. Dahlman
Award: Delivery Order
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

Status: Design work for this project is underway. The contractor is reviewing noted problems with MSIS identifiers on a state-by-state basis, particularly in states that use SSN as their "unique" MSIS identifier. Results from recently completed work by the Census Bureau on the Medicaid "undercount" project have provided insight into identifier problems. There was an extention of the period of performance to June 30, 2008. The extension was required to provide sufficient time to complete work on the development of a National Medicaid Person Summary.

Description: This project will create a national Person Summary file for MAX in flat-file format. In order to create this file, it will be necessary to develop an algorithm to unduplicate individuals across States and over time, using data elements such as IDs - Medicaid and Medicare, Social Security number, date of birth and gender. In addition, it will be necessary to analyze the potential for both type 1 and type 2 errors in the unduplication process. There are a number of reasons for mismatches, including one enrollee reporting another person's SSN as their own, missing or erroneous SSNs and reporting of Individual Tax Identification Numbers-ITINs - as SSNs. The eventual aim in the process of creating this national Person Summary filed for MAX is to: (1) develop more accurate estimates of national Medicaid enrollment, (2) assist data users who need to conduct research on more than one State, and (3) assist users that need to build longitudinal cohorts of enrollees. ■

Development of Medication Measures for CKD and ESRD

Project No: 500-00-0037/10
Project Officer: Christie Cahee
Fatima Millar
Period: September 2005 to May 2007
Funding: $1,188,187
Principal Investigator: Barry Chaiken
Award: Task Order (RADSTO)
Awardee: Bearing Point
1676 International Drive
McLean,VA 22102-4828

Status: The contractor submited a final project report and the contract period of performance ended May 30, 2006.

Description: This task order will identify those measures that can be used by QIOs and the ESRD Networks to establish a baseline for medication use in CKD/ESRD patients as well as identify drug-related issues specific to this population. Development of CKD/ESRD medication measures will allow for tracking of prescribing and therapeutic monitoring patterns of those drugs specific to these patients, as well as monitoring of the quality of care provided to those patients. ■

Development of Physician Measures

Project No: 500-00-0033/11
Project Officer: Latousha Leslie
Period: September 2005 to March 2007
Funding: $1,046,568
Principal Investigator: Myles Maxfield
Award: Task Order
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The project ended on March 29, 2007.

Description: The purpose of this task order is for the development of physician measures based on administrative data from electronic health records or paper medical records and other relevant claims-based or administrative data sources. Physician measures shall be selcted and developed for quality improvement and intervention, public reporting, and pay-for-performance demonstrations and for use by QIOs. While some measures may be used specifically for pay-for-performance, quality improvement or public reporting, it is conceivable that some measures may be used for multiple purposes. The measures to be developed, to the extent feasible, shall be based on the Insitute of Medicine's (IOM) domains of safety, effectiveness, patient-certered, timeliness, efficiency, and equitability. ■

Diamond State Health Plan

Project No: 11-W-00036/03
Project Officer: Diane Gerrits
Period: May 1995 to December 2009
Funding: $0
Principal Investigator: Harry Hill
Award: Waiver-Only Project
Awardee: Delaware Health and Social Services (New Castle)
P. O. Box 906, Lewis Building
New Castle, DE 19720

Status: The Demonstration was approved for a three-year extension on December 21, 2006. The State is currently considering additional cost containment measures to ensure that their budget neutrality limit is not exceeded.

Description: The Diamond State Health Plan Demonstration (DSHP) implements mandatory Medicaid managed care, and uses savings to cover additional parents and uninsured adults with incomes up to 100 percent of the federal poverty level (FPL). The State provides the majority of their Medicaid services through the Demonstration. Medicare beneficiaries, persons residing in institutions or receiving home and community based waiver services, presumptively eligible pregnant women, unqualified aliens and Individuals enrolled in the Breast and Cervical Cancer Treatment Program are excluded from DSHP. Extended family planning services are also provided for women who would otherwise lose Medicaid eligibility 60 days post-partum for a period of two years. ■

Disabled and Special Needs Populations: Examining Enrollment, Utilization, and Expenditures

Project No: 500-00-0047/01
Project Officer: James Hawthorne
Period: September 2000 to November 2006
Funding: $1,024,697
Principal Investigator: Carol Irvin
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: An additional analysis of the cost and use of services by individuals with behavioral health disorders has been added to the project. The project was completed on November 30, 2006 and a final report has been posted on the ORDI Web site.

Description: The purpose of this project was to create a linked database that combines information from the Social Security Administration's (SSA) administrative data with CMS Medicaid and Medicare data. It complements and builds upon activities related to these special needs populations by other components of the Department of Health and Human Services. One group of studies will link Medicaid and SSA data in order to examine enrollment dynamics between Medicaid and the Supplemental Security Income and the Social Security Disability Insurance Programs and to determine whether inter-program enrollment dynamics vary by characteristics of enrollees—such as work status, disabling condition, severity of condition, state of residence, race/ethnicity, or age group.

Using the same data, another study will help CMS develop a more complete understanding of children with special health care needs enrolled in the Medicaid program. Specifically the study will develop estimates of the number of children with special health care needs enrolled in Medicaid, as this population is defined by the Balanced Budget Act of 1997 interim rule, their demographic characteristics, and utilization and expenditure patterns. A final study will link SSA disability data, Medicare, and Medicaid data for a sample of Medicare beneficiaries with behavioral health problems. The purpose of this study is to develop a much more complete understanding of utilization and expenditures for Medicare beneficiaries with behavioral health disorders. ■

Dual Eligible Research, Evaluation, and Demonstration Data Support and Analysis

Project No: 500-01-0035/01
Project Officer: Susan Radke
Period: September 2004 to December 2006
Funding: $39,986
Principal Investigator: Dan Gilden
Award: Task Order (ADDSTO)
Awardee: JEN Associates, Inc.
P.O. Box 39020
Cambridge, MA 02139

Status: The contract ended in 2006.

Description: CMS manages and provides Federal oversight to dually eligible demonstration programs that integrate Medicaid and Medicare financing and service delivery health care for dually eligible beneficiaries. CMS partners with State Medicaid agencies and Medicare managed care organizations to implement dually eligible waivers demonstration projects. CMS needs to use existing Medicare and Medicaid linked data sets to develop waiver cost estimates for the dually eligible demonstration waivers and to develop as well as implement Medicaid and Medicare dually eligible research and evaluation studies. The contractor is approved by CMS to serve as custodian for various State data files that include linked Medicare and Medicaid data sets. The purpose of the contract was to enable JEN Associates, Inc. to:

(1) Continue Data Use Agreements (DUAs) for State data sets managed by the contractor and enable data re-use for CMS sponsored or approved intramural and extramural research. (2) Continue DUAs for Medicare data sets and enable data re-use for CMS sponsored or approved intramural and extramural research. (3) Collect most recent years of Medicare and Medicaid data from CMS and a limited number of States to create additional dual eligible or pharmacy files as may be necessary for either program development or research and evaluation purposes (4) Compile a national 5-percent Medicare/ Medicaid linked file for dually eligible beneficiaries. (5) Assist in the preparation of one or more Medicare/ Medicaid waiver cost estimates. (6) Present to CMS a demonstration of the JEN decision support methodology developed for application using State and other data sources. ■

Econometric Forecasting and Economic Services

Project No: 500-2006-00037G (GS-10F-0318K)
Project Officer: Mary Lee Seifert
Period: April 2006 to April 2008
Funding: $1,217,101
Principal Investigator: John Larson
Award: Contract
Awardee: Global Insight Incorporated
1850 M Street NW, Suite 1100
Washington, DC 20036

Status: This contract continues year-to-year since it provides basic support for our actuarial estimates used in operating the Medicare Program. The contractor has also constructed forecasts of CMS's input price indexes on a quarterly basis and has provided assistance with OACT work on the President's Budget and Trustees Report. In the past year, the contract was modified to extend the period of performance to April 2008, and also increase the funding by $696,362.

Description: This project is a multi-year project and provides econometric forecasting and other economic services to CMS. It also provides for forecasts and maintenance of CMS input price indexes for use in updating payments in the various prospective payment systems. The project also allows for various other economic studies and analyses concerning healthcare-related, and input price index issues including health sector compensation trends, and analysis of malpractice liability premium growth. ■

Educational Intervention with HIV Infected Patients: A Randomized Study, An

Project No: 25-P-92351-4/02
Project Officer: Richard Bragg
Period: September 2004 to November 2007
Funding: $249,495
Principal Investigator: Jose Castro
Award: Grant
Awardee: University of Miami School of Medicine
1800 NW 10th Ave.
Miami, FL 33136

Status: The project will end on November 29, 2007. This project is awarded under the Hispanic Health Services Research Grant Program.

Description: This project is a collaborative effort of the University of Miami School of Medicine's AIDS Clinical Research Unit (ACRU), the Miami Drug Abuse & AIDS Research Center, and the Jackson Memorial Hospital HIV/AIDS Clinical Program.

The purpose of this project is to implement and evaluate the effectiveness of culturally sensitive, structured educational sessions for Hispanic American HIV-infected patients seen in the outpatient setting using a two-group randomized design. This randomized intervention study will seek to determine whether or not structured educational sessions improve outcomes of HIV infected patients.

The sessions will be conducted in the primary language of the participants and will be given by an educator who is fluent or native of that language. The session will be interactive and will include the following: (1) HIV Care Basics, (2) HIV Treatments, and (3) Antiretroviral Therapy Basics. ■

Empirical Analysis of a New Payment System

Project No: 500-00-0032/10
Project Officer: Ann Meadow
Period: September 2004 to February 2008
Funding: $1,225,039
Principal Investigator: Marian Wrobel, Ph.D.
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project has produced detailed Kume trend analyses of the frequencies of payment adjustments; analyses of utilization patterns and impacts of various payment adjustments; analysis of HHA margins; and simulations of selected modifications to the payment system. Results were discussed at several meetings of a home health prospective payment system (HHPPS) Technical Expert Panel in late 2005 and early 2006. The Period of Performance was extended in September 2007.

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. ■

End-Stage Renal Disease (ESRD) Disease Management Demonstration: United Healthcare Insurance Co. (Evercare)

Project No: 95-W-00186/05
Project Officer: Maria Sotirelis
Period: January 2006 to December 2009
Funding: $0
Award: Waiver-Only Project
Awardee: United Healthcare Insurance Company
9900 Bren Road East, Mail Route MN008-T440
Minnetonka, MN 55343

Status: Enrollment is continuing as the demonstration progresses.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. Ordinarily, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage plans. This demonstration makes an exception to the rule, allowing MA organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis/MA organization must provide all Medicare covered benefits. Organizations serving ESRD patients will receive the same risk-adjusted ESRD capitation payments as for the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities. United Healthcare Insurance has two ESRD only MA special needs plans operating under this demonstration. These plans are Evercare of Georgia and Evercare of Arizona. The first plan, Evercare of Georgia, started enrolling in February 2006 and Evercare of Arizona began enrollment in January 2007.

The actual payment amount is reduced by 5 percent and will be made available depending on performance on quality measures. CMS has determined six dialysis-related indicators on which performance will be assessed. The indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, Arbor Research. ■

End-Stage Renal Disease (ESRD) Disease Management Demonstration: Fresenius Medical Care North America (FMCNA) and Fresenius Medical Care Health Plan (FMCHP)

Project No: 95-W-00187/01
Project Officer: Heather Grimsley
Period: January 2006 to December 2009
Funding: $0
Award: Waiver-Only Project
Awardee: Fresenius Medical Care North America (FMCNA)
920 Winter Street
Waltham, MA 02451-1457

Status: The organization began enrolling patients January 1, 2006. The total enrollment in all FMCHP plans as of November 2007 is 693 beneficiaries.

In 2008, FMCHP plans are available to beneficiaries with ESRD in select counties in the following states: Alabama, California, Connecticut, Illinois, Massachusetts, Minnesota, New York, Pennsylvania, Rhode Island, Tennessee, and Texas.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. Ordinarily, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage (MA) plans. This demonstration makes an exception to the rule, allowing MA organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis/MA organization must provide all Medicare covered benefits. Organizations serving ESRD patients will receive the same risk-adjusted ESRD capitation payments as the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities.

The actual payment amount, however, will be reduced by 5 percent, which will be available to the organizations depending on performance on quality measures. CMS has determined six dialysis-related indicators on which performance will be assessed. These indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in

consultation with participating organizations and with the CMS implementation contractor, Arbor Research Collaborative for Health. ■

End-Stage Renal Disease Disease Management Demonstration: DaVita/SCAN

Project No: 95-W-00188/09
Project Officer: Siddhartha Mazumdar
Period: January 2006 to December 2009
Funding: $0
Principal Investigator: Chris Mayne
Award: Waiver-Only Project
Awardee: DaVita, Inc.
601 Hawaii Street
EL Segundo, CA 90245

Status: The organization began enrolling patients on January 1, 2006. The enrollment as of the end of calendar year 2007 was 368.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. Ordinarily, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage plans. This demonstration makes an exception to the rule, allowing MA organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis/MA organization must provide all Medicare covered benefits. Organizations serving ESRD patients will receive the same risk-adjusted ESRD capitation payments as for the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities.

The actual payment amount, however, will be reduced by 5 percent, which will be available to the organizations depending on performance on quality measures. CMS has determined 6 dialysis-related indicators on which performance will be assessed. These indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, the University Renal Research and Education Organization (URREA). ■

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

Status: The contract has been completed. The final report is located here:

http://www.cms.hhs.gov/Reports/downloads/Adamache.pdf

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. Quantitative analyses were also performed pertaining to physician profiling for echocardiograms, MRIs, and CT scans. ■

Episode Grouper Software Evaluation

Project No: 500-01-0031/02
Project Officer: Fred Thomas
Period: March 2006 to December 2007
Funding: $344,275
Principal Investigator: Thomas MaCurdy
Award: Task Order (ADDSTO)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contract was modified to revise the end date of the Period of Performance from April 20, 2007 to February 2008.

Description: The purpose of this task order is to test and evaluate two episode grouping software packages and to determine whether these packages might be used with Medicare data. The project team will assess how each of the groupers works, and how they work with real Medicare data. Issues to be addressed include how each grouper adjusts for disease risk and the building of resource use profiles for physicians. This task order is fully funded. ■

ESRD Measures Support Work

Project No: HHSM-500-2005-000311/01
Project Officer: Thomas Dudley
Period: February 2006 to October 2008
Funding: $2,107,286
Principal Investigator: Robert Wolfe
Award: Task Order (MRAD)
Awardee: University of Michigan Kidney Epidemiology and Cost Center
315 West Huron, Suite 420
Ann Arbor, MI 48103

Status: The contract has been modified to revise the Period of Performance ending date from 06/08/2008 to 10/31/2008. It is mutually agreed between the Government and the Contractor that this action does not increase the total estimated cost plus fee of this Task Order.

Description: The purpose of this task order is to outline the tasks to be conducted to develop, implement and maintain ESRD quality measures that can be used for quality improvement and intervention, evaluation and monitoring of the Medicare ESRD Program, public reporting, and potentially for pay-for-performance. ■

Establishing PACE (Program of All-inclusive Care for the Elderly) in Rural Vermont

Project No: 18-P-93116/1-01
Project Officer: Jean Close
Period: September 2005 to February 2007
Funding: $744,000
Principal Investigator: Elizabeth Davis
Award: Grant
Awardee: PACE Vermont, Inc.
61 Fairmount Street
Burlington, VT 05401

Status: Grant goals were met. PACE Vermont submitted an application to CMS to expand services to the rural Rutland area.

Description: PACE was established through Congress as a permanent provider under Medicare in 1997. PACE programs provide and coordinate all needed preventive, primary, acute, and long-term care services for frail, vulnerable elders, so they may remain in the community as long as possible. PACE has been well-demonstrated as successful in urban areas. The goal of this project is to demonstrate and evaluate the feasibility of replicating the PACE model in a rural setting. This includes: careful documentation of the implementation experience; estimation of necessary start-up and operational costs; and collaboration with existing providers of long-term and acute care. ■

Evaluation and Support of System Change Grants

Project No: HHSM-500-2004-00055C
Project Officer: Cathy Cope
Period: September 2004 to March 2008
Funding: $1,496,495
Principal Investigator: Janet O'Keefe
Edith Walsh
Award: Contract

Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: A compendium of all RCSC Grants awarded from 2001 through 2005 has been completed. A review of all semi-annual reports was completed. Topics for more in-depth analysis were chosen and are underway.

Description: The purpose of this contract is to conduct formative and summative research and evaluation of 2004 Real Choice Systems Change Grants including Comprehensive Family to Family, Housing, Life Accounts, Mental Health System Transformation, Portals from EPDST to Adult Supports, Rebalancing, and Quality Assurance and Quality Improvement in Home and Commmunity based services. ■

Evaluation and Testing of the Nursing Home Quality Initiative (NHQI), and the Home Health Quality Initiative (HHQI)

Project No: 500-00-0032/11
Project Officer: Phyllis Nagy
Period: September 2004 to November 2006
Funding: $608,920
Principal Investigator: Henry Goldberg
R. Andrew Allison
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Work under this task order has been completed. Final reports have been submitted regarding: (1) Spanish language testing of the Home Health Compare website; (2) a consumer survey and examination of the consumer decisionmaking process relative to long-term care; and (3) a survey of home health agencies regarding impacts of the Home Health Quality Initiative.

Description: The purpose of this project was to evaluate and test components of two CMS quality initiatives - Nursing Home Compare and Home Health Compare. This project was implemented to assist information intermediaries and (ultimately) consumers in their efforts to make informed choices. It was anticipated that such choices would be enabled via familiarization with data about the quality of care rendered by nursing homes and home health agencies. ■

Evaluation of Balanced Budget Act (BBA) Impacts on Medicare Delivery and Utilization of Inpatient and Outpatient Rehabilitation Therapy Services

Project No: 500-00-0030/02
Project Officer: Philip Cotterill
Period: September 2001 to May 2007
Funding: $1,028,631
Principal Investigator: Barbara Gage
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Status: This is a continuation and extension of previous work, "Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes" (contract number 500-96-0006/04), which covered the period 1996 to 1999. The final report, comprises five separate papers: Changes in the Supply of Medicare Post Acute Care Providers; A New Era: Post Acute Use Under PPS; Changes in Inpatient Rehabilitation Facility Use: Pre and Post PPS; Inpatient Rehabilitation Facilities: Alternative Specialization; and Post Acute Care: Opportunity for Efficiency or Just Another Balloon Popping? For information about these papers, contact Barbara Gage at RTI (bgage@rti.org).

Description: This project studied the impact of the Balanced Budget Act of 1997 (BBA) on the delivery and utilization of inpatient and outpatient rehabilitation therapy services to Medicare beneficiaries. Many of the BBA changes directly affected payment for rehabilitation therapy services. These policies, most now implemented, included per beneficiary therapy limits applicable to certain outpatient settings,the skilled nursing facility prospective payment system, the home health agency prospective payment system, the inpatient rehabilitation facility prospective payment system, the long-term care hospital prospective payment system, and the outpatient therapy prospective payment system. The project studied the period 2000 to 2004. ■

Evaluation of Capitated Disease Management Demonstration

Project No: 500-00-0033/03
Project Officer: James Hawthorne
Period: September 2003 to September 2007
Funding: $881,200
Principal Investigator: Robert Schmitz
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Capitated Disease Management demonstration was not implemented and the evaluation project was terminated. The contract has ended.

Description: The purpose of this project is to evaluate the effectiveness of Medicare Capitated Disease Management Demonstration for beneficiaries with chronic medical conditions such as stroke, congestive heart failure, and diabetes; people who receive both Medicare and Medicaid (dually eligible beneficiaries); or frail elderly patients that would benefit from a greater coordination of services.

This demonstration uses disease management interventions and payment for services based on full capitation with risk sharing options to: (1) improve the quality of services furnished to specific eligible beneficiaries, including the dual eligible and frail elderly; (2) manage expenditures under Part A and Part B of the Medicare program; and (3) encourage the formation of specialty plans that market directly to Medicare's sickest beneficiaries. ■

Evaluation of Care and Disease Management Under Medicare Advantage

Project No: HHSM-500-2006-00009I/04
Project Officer: Noemi Rudolph
Period: August 2007 to November 2009
Funding: $495,016
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is ongoing.

Description: This Task Order will design and implement a qualitative evaluation of care and disease management programs under Medicare Advantage. Through the study, CMS seeks to understand they types 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 effectivenees of these programs for the Medicare population. The contractor will be responsible for the analysis of primary data collected via interviews of, surveys of, and/or site visits to participating organizations supplemented by any documents provided by the plans as well conducting a review of the available literature. ■

Evaluation of Competitive Acquisition Program for Part B Drugs

Project No: 500-00-0024/24
Project Officer: Jesse Levy
Period: September 2005 to December 2008
Funding: $1,305,147
Principal Investigator: Ed Drozd
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The contract was modified to reduce the level of effort and delete specified tasks within both phases of this task order. It was also modified to add funding for Phase II of this task order. A report to Congress is due July 1, 2008.

Description: The purpose of this task is to provide evaluative information about a new component of the Medicare program. Section 303(d) of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173) establishes a competitive acquisition program (CAP) for Medicare Part B-covered drugs and biologicals. The CAP is intended to be an alternative to the Medicare Average Sales Price methodology adopted under Section 303(c), which was instituted in January 2005. Under CAP, a physician does not buy drugs and biologicals for reimbursement at the ASP payment allowance limit, but instead receives them from a vendor who has won a drug supplier contract

through a competitive bidding process. This task order consists of two phases, both phases have been funded. ■

Evaluation of Demonstration of Competitive Bidding for Medicare Cliical Laboratory Services

Project No: 500-00-0024/26
Project Officer: Ann Meadow
Period: September 2005 to September 2008
Funding: $757,553
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

Status: Phases I and II have been exercised. The level of effort within all three phases has been reduced.

Description: Section 302(b) of The Medicare Modernization Act of 2003 (Public Law 108-173) (MMA) requires CMS to test competitive bidding for clinical laboratory services under a demonstration project. The demonstration, currently in the design state, is to cover laboratory services otherwise payable under the Medicare Part B laboratory fee schedules; pathologist services under the Medicare Physician Fee Schedule are not included. The law requires a series of Reports to Congress on the demonstration, including an initial progress report on the design that is not part of the proposed Scope of Work. The purpose of this project is to provide information for two additional Reports to Congress on the progress and outcomes of the demonstration. The award under this task is expected to result in technical reports detailing findings for attachment to the Reports to Congress. ■

Evaluation of Demonstration to Improve the Direct Service Community Workforce

Project No: 500-00-0051/03
Project Officer: Kathryn King
Period: September 2003 to December 2006
Funding: $394,403
Award: Task Order (RADSTO)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: The Lewin Group completed all of the site-specific plans, developed the web-based reporting tool that allows the grantees to submit electronic quarterly reports to CMS, designed the evaluation design for the National Demonstration Program, produced a PROCESS EVALUATION of the 10 grantees, helped design a DSW Intensive & DSW Breakout session for the 2006 NFI Conference in April 2006, continued to provide evaluation assistance to grantees as their interventions evolve, and is completed two promising practices articles. The project is now complete.

Description: The purpose of this task order is to assist the 10 demonstration projects to develop a site-specific evaluation plan, develop a web-based reporting tool, develop an evaluation design for the National Demonstration Program, and develop a series of promising practices about the ability of the demos to improve the recruitment and retention of direct service workers. Information on this demonstration is available at www.cms.hhs.gov/newfreedom/default.asp. ■

Evaluation of DRG Classification Systems

Project No: HHSM-500-2005-00028I/01
Project Officer: Philip Cotterill
Period: September 2006 to March 2008
Funding: $487,199
Award: Task Order (MRAD)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: This task order is now fully funded. The period of performance is now 9/01/2006 through 3/01/2008. All other terms and conditions remain unchanged and in effect.

Description: This task order will conduct an independent evaluation of the alternative severity refinement systems available to CMS. The results of this evaluation are needed in time for inclusion in the FY 2008 proposed IPPS rule. ■

Evaluation of End Stage Renal Disease (ESRD) Disease Management (DM)

Project No: 500-00-0028/02
Project Officer: Diane Frankenfield
Period: September 2003 to September 2008
Funding: $1,628,359
Principal Investigator: Frederich Port, M.D.
Award: Task Order (RADSTO)
Awardee: Arbor Research Collaborative for Health formerly known as URREA (University Renal Research and Education Association)
315 West Huron, Suite 260
Ann Arbor, MI 48103

Status: The evaluator has conducted a patient satisfaction data collection tool and is remeasuring this with follow up interviews. They will soon be collecting information on provider satisfaction, and collecting and analyzing data regarding clinical outcomes, reasons for disenrollment, quality of life and cost analyses.

Description: This Task Order is for an independent evaluation of the ESRD-DM Demonstration (DMD) that will examine case-mix, patient and provider satisfaction, outcomes, quality of care, and costs and payments. The Request for Proposals for providers to participate in the DMD was published in the Federal Register on June 4, 2003. The DMD will enroll Medicare beneficiaries with ESRD into fully capitated ESRD disease management organizations. The evaluation contractor will work with the DM sites to collect and analyze data to measure clinical, quality of life, and economic outcomes. When the DM sites are selected, the evaluation team will work with them to design and implement data collection instruments and mechanisms. ■

Evaluation of Gainsharing Demonstration

Project No: HHSM-500-2005-00029I/03
Project Officer: William Buczko
Period: September 2006 to September 2010
Funding: $2,068,665
Principal Investigator: Jerry Cromwell
Award: Contract
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Participating hospitals have been selected. The demonstration is slated to begin on 1/1/2008.

Description: Section 5007 of the Deficit Reduction Act of 2005 requires the Secretary to establish a qualified gainsharing demonstration program. Under this demonstration, the Secretary shall test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the qulaity and efficiency of care provided to beneficiaries. Methodologies to develop improved operational and financial hospital performance with sharing of gains as specified in the project will also be evaluated. The demonstration requires arrangements between a hospital and physicians under which the hospital provides for gainsharing payments to the physicians who represent solely a share of the savings incurred directly as a result of collaborative efforts between the hospital and the physician. The demonstration will operate six projects, two in rural areas. ■

Evaluation of Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00022I/01
Project Officer: William Buczko
Period: September 2007 to September 2010
Funding: $447,032
Principal Investigator: D. Hittle
Award: Task Order (MRAD)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The evaluation kickoff meeting was held in October, 2008. The demonstration team is in the process of selecting sites for a planned 1/1/2008 start of operations.

Description: The Home Health Pay for Performance (HHP4P) demonstration is part of a CMS initiative to improve the quality of care furnished to all Medicare

beneficiaries receiving care from home health agencies (HHAs). This demonstration will test the "pay for performance" concept in the HHA setting. Under this demonstration, CMS will provide financial incentives to participating HHAs that meet certain standards for providing high quality care. Participation of HHAs in this demonstration will be voluntary. CMS will assess the performance of participating HHAs based on selected measures of quality of care, then make payment awards to those HHAs that either achieve a high level of performance or show exceptional improvement based on those measures. The quality measures include acute care hospitalizations, use of emergent care as well as outcome measures from Outcome and Assessment Information Set (OASIS).

This demonstration will select 4 states/stage groups (one from each region of the U.S.) that will be able to provide a representative sample of Medicare HHAs nationwide. In cases where individual states within a region do not have a sufficient number of HHAs to ensure a large enough service population, contiguous, multi-state groups will be selected instead. Within each state/state group, HHAs electing to participate will be randomly assigned to treatment and control groups. The demonstration will include all Medicare beneficiaries that are in a participating HHA. Some of these beneficiaries will also be eligible for Medicaid. ■

Evaluation of Inpatient PPS Reform

Project No: HHSM-500-2005-00025C
Project Officer: Fred Thomas
Period: August 2005 to April 2008
Funding: $247,048
Principal Investigator: Richard Averill
Award: Contract
Awardee: 3M-Health Information Systems
100 Barnes Road
Wallingford, CT 06492

Status: The final report is being reviewed for publication.

Description: Section 507 of the MMA requires the Medicare Payment Advisory Commission (MedPAC) and the Secretary of the Department of Health and Human Services (HHS) to study physician-owned cardiac, surgery, and orthopedic specialty hospitals and to report the results of their studies to Congress. The MedPAC study was delivered to Congress on March 8, 2005 and the HHS study was delivered on May 12, 2005. After consideration of the results of the studies, CMS stated that it would assess methodological reforms related to payments for inpatient hospital services. Four reforms were identified by CMS for evaluation in the recommendations section to the Section 507(c) study. This contract will evalute the four reforms: 1) Refine DRGs to more fully capture differences in severity of illness; 2) Base DRG weights on estimated cost of providing care; 3) Base DRG weights on national average of hospitals' relative values in each DRG; and 4) Adjust DRG weights to account for differences in prevalence of high-cost outlier cases. ■

Evaluation of Low Vision Rehabilitation Demonstration (LVRD)

Project No: 500-00-0031/06
Project Officer: Pauline Karikari-Martin
Period: September 2005 to September 2010
Funding: $499,582
Principal Investigator: Christine Bishop
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The period of performance for Phase I has been extended to December 2008. Phases III and IV have been deleted from the contract.

Description: This Task Order is to conduct an evaluation of the Centers for Medicare and Medicaid Service's (CMS') Low Vision Rehabilitation Demonstration (LVRD). The contractor will be required to design and conduct the evaluation of the demonstration. The evaluation will include both qualitative and quantitative assessments. The qualitative part will examine issues pertaining to the implementation and operational experiences of the patients, practitioners and the government. Data sources are likely to include surveys for patient data and site visits and focus groups for provider data. For the quantitative analyses the main data source will be CMS administrative and billing data files. The contractor will be required to conduct various statistical analyses, using individual level data, to examine issues related to quality of care and impacts on the use and costs of services. ■

Evaluation of Medicare Advantage Special Needs Plans

Project No: 500-00-0033/13
Project Officer: James Hawthorne
Period: September 2005 to June 2008
Funding: $1,005,970
Principal Investigator: Robert Schmitz
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Report to Congress was submitted for clearance in July, 2007. The Final Report will become available once the report has been transmitted to Congress. Additional funds were provided due to an increase level of effort under Option year 1.

Description: Section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (PL 108-173), more commonly known as the Medicare Modernization Act (MMA), amended section 1859(b) of the Social Security Act allowing the creation of Medicare Advantage Special Needs Plans (SNPs) to serve individuals with special needs. The purpose of this task order is to examine the implementation and operational experiences of the participating organizations. The evaluation shall include an assessment of the quality of services provided to enrollees by SNPs and the costs and savings to the Medicare program for care provided to enrollees in SNPs compared to enrollees in other settings such as regular MA plans, chronic care improvement programs, and private fee-for-service plans. A major component of the evaluation will be detailed case studies of the SNP plans. It will also include statistical analyses of secondary data to fully characterize the special needs populations being served and the cost of the services provided by SNPs. The case studies will require site visits to a representative sample of SNPs as well as interviews with appropriate State Medicaid officials. ■

Evaluation of Medicare Health Care Quality Demonstrations - Phase I

Project No: 500-00-0024/22
Project Officer: David Bott
Period: September 2005 to September 2009
Funding: $560,425
Principal Investigator: Shulamit Bernard
Michael Trisolini
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This is phase one of the contract, which will be in three phases. A two year no-cost extension was recently granted, slated to end in September 2009.

Description: The Contractor is required to design and conduct an independent evaluation of the Medicare Health Care Quality (MHCQ) Demonstration Projects. The evaluation will include an assessment of each demonstration project approved by the Secretary with respect to Medicare expenditures, beneficiary and provider satisfaction, and health care delivery quality and outcomes. ■

Evaluation of MMA Changes on Dual Eligible Beneficiaries in Demo and Other Managed Care and Fee-For-Service Arrangements, An

Project No: 500-00-0031/03
Project Officer: William Clark
Period: September 2004 to September 2009
Funding: $674,065
Principal Investigator: Christine Bishop
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The contractor has conducted demonstration site visits and is preparing a report on the delivery of integrated care demonstration characteristics. Phase II is planned to commence in 2006.

Description: This project is an evaluation of the Medicare Modernization Act's changes on beneficiaries in dual eligible Medicare Advantage Special Needs Plans demonstrations that also contract for comprehensive Medicaid benefits. Phase II will examine the transition of pharmacy benefits from Medicaid to Medicare under Medicare Part D. ■

Evaluation of MMA Section 702 Demonstration: Clarifying the Definition of Homebound

Project No: 500-00-0033/06
Project Officer: Ann Meadow
Period: January 2005 to July 2008
Funding: $639,859
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor developed a beneficiary survey and conducted site visits and other qualitative data collection. The survey has not been administered due to low enrollment in the demonstration. The project plan has been modified to address selected research questions, including several that can be answered using information from home health agencies in the demonstration States. The final Report to Congress has been completed, and was submitted to Congress in January 2008.

Description: This project supports a congressionally mandated evaluation of a demonstration required under the 2003 Medicare Modernization Act. Section 702, "Demonstration Project to Clarify the Definition of Homebound," requires the Secretary of Health and Human Services to conduct a 2-year demonstration to test the effect of deeming certain beneficiaries homebound for purposes of meeting the Medicare home health benefit eligibility requirement that the patient be homebound. Under the law, the demonstration is to be conducted in 3 States (representing Northeast, Midwestern, western regions), with an overall participation limit of 15,000 persons.

Section 702 requires the Secretary to collect data on effects of the demonstration on quality of care, patient outcomes, and any additional costs to Medicare. A report to the Congress addressing the results of the project is to specifically assess any adverse effects on the provision of home health services, and any increase (absolute and relative) in Medicare home health expenditures directly attributable to the demonstration. The Report is also to include recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purposes of absences from the home to qualify for home health services without incurring additional costs to the Medicare program. The purpose of the evaluation project is develop the information Congress seeks, to produce a technical evaluation report to accompany the Report to Congress, and to provide CMS with a sound basis for making the mandated recommendations. ■

Evaluation of MSA Plans Offered under the Medicare Program

Project No: HHSM-500-2006-00009I/06
Project Officer: Melissa Montgomery
Period: August 2007 to August 2009
Funding: $428,227
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is underway.

Description: This task order will conduct an evaluation of Medical Savings Account (MSA) plans offered under the Medicare program. MSAs representa an additional choice available to beneficiaries beyond the stand fee-for-service Medicare and other Medicare Advantage (MA) plans. They combine the features of a high deductible health plan with a personal savings account with the aim of encouraging a beneficiary to be more judicious in the use of health care services. This evaluation will examines early patterns of enrollment and the development of the MSA market in Medicare. The task order also includes an option to conduct a survey of beneficiaries to compare determinants of plan choice, service utilization and out-of-pocket spending between MSA participants and beneficiaries enrolled in traditional Medicare and MA plans. ■

Evaluation of National DMEPOS Competitive Bidding Program

Project No: 500-00-0032/14
Project Officer: Ann Meadow
Period: September 2005 to September 2010
Funding: $2,331,309
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Baseline beneficiary and supplier survey work in three sites has been completed, as has a report on accreditation and site visits to three sites.

Description: Section 302(b) of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) (MMA) requires the Centers for Medicare and Medicaid Services (CMS) to begin in 2007 a program of competitive bidding for durable medical equipment (DME), supplies, certain orthotics, and enteral nutrients and related equipment and supplies in 10 Competitive Acquisition Areas (CAAs). MMA Section 303(d) requires a Report to Congress on the program by July 2009. This project's purpose is to provide information for the Report to Congress on access to and quality of DME, beneficiary satisfaction with DME items and services, program expenditures, and impacts on beneficiary cost-sharing. Data collection activities include beneficiary and supplier surveys, focus groups with suppliers and referral agents, and key informant discussions with beneficiary groups or advocates, CMS officials or CMS' bidding contract managers, referral agents and suppliers. ■

Evaluation of Phase I of Medicare Health Support (formerly Voluntary Chronic Care Improvement)

Project No: 500-00-0022/02
Project Officer: Mary Kapp
Period: September 2004 to September 2010
Funding: $2,662,583
Principal Investigator: Nancy McCall
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: These pilot programs have been implemented under the name Medicare Health Support. Eight oganizations 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. A Report to Congress issued in June 2007 (www.cms.hhs.gov/Reports/Downloads/McCall.pdf) provides an overview of the scope of the programs, their design and early implementation experience, as well as preliminary cost and quality findings. Participation rates in the first 6 month period range from 65% to 92%. 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. Analyses to assess the programs' impact on clinical quality, beneficiary satisfaction, and financial impacts are ongoing.

Description: The purpose of this project is to independently evaluate chronic care improvement programs implemented under the developmental phase (Phase I) of the Voluntary Chronic Care Improvement Under Traditional Fee-for-Service Medicare initiative as authorized by Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). ■

Evaluation of Pilot Program for National State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities or Providers

Project No: 500-00-0015/03
Project Officer: Beth Benedict
Period: September 2005 to September 2008
Funding: $999,938
Principal Investigator: Alan White
Award: Task Order

Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: A task order to conduct the evaluation was awarded to Abt Associates, Inc. in September 2005. The project was extended to September 30, 2008. The demonstration was completed on in September 2007. Data collection is finished and the evaluation report is being prepared.

Description: The purpose of this task order will be to conduct an evaluation of the Background Check Pilot Program, authorized under Section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) to "identify efficient, effective and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees." This Task Order has been fully funded. ■

Evaluation of Programs of Coordinated Care and Disease Management

Project No: 500-95-0047/09
Project Officer: Carol Magee
Period: September 2000 to March 2008
Funding: $4,032,922
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The First and Second RTC have been released and are available. There is wide disparity in the enrollment success of the various sites, and locating and convincing patients to enroll has been harder overall than anticipated.

The Third Report to Congress, due in April 2008, is in clearance.

Description: This 5-year evaluation project will describe and assess sixteen

congressionally-mandated Medicare Coordinated Care Demonstration Programs, each providing a particular set of coordinated care interventions to fee-for-service (FFS) Medicare beneficiaries with one or more selected chronic illnesses (e.g., Diabetes, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Hyperlipidemia, Stroke, Renal or Hepatic Disease, Coronary Artery Disease, Cancer). Demonstration of the effectiveness of programs of care coordination or management has historically been complicated by wide variations in program staff, funding mechanisms, interventions, and stated goals. The Balanced Budget Act of 1997 mandated demonstrations in separate program sites to implement approaches to coordinated care of chronic illnesses, along with an independent evaluation, for CMS to investigate the potential of care coordination and/or case management to improve care quality and control costs in the Medicare FFS Program. An evaluation of best practices in coordinated care and a study of demonstration design options were conducted.

The 16 CMS-funded demonstration programs being studied as a part of this evaluation vary widely with respect to the demographics, medical, and social situations of the target population, intensity of services offered, interventions under study, type(s) of health care professionals delivering the interventions, and other factors. Each demonstration program has a randomized design, with a treatment arm and a 'usual care' arm. The evaluation can thus test each unique program's effects upon patient outcome(s)/well-being, patient satisfaction, provider behavior and satisfaction, and Medicare claims - attributable to particular methods of managing care in the FFS Medicare environment, and as compared to the respective "usual care," non-intervention patient group.

The overall goals of this evaluation are to identify those characteristics of the programs of coordinated care under study that have the greatest impact on health care quality and cost and to identify the target populations most likely to benefit from such programs. In addition to analysis plans specific to each program/site, the evaluation contractor will conduct a process analysis to describe the interventions in detail, with a key goal of assessing what factors account for program success or failure. The study will include successive case studies of each of the 16 sites, interim and final site specific reports, two interim summary reports, two Reports to Congress (based on the interim summary reports), and a final summary report. ■

Evaluation of Programs of Disease Management (Phase I and Phase II)

Project No: 500-00-0033/02
Project Officer: Lorraine Johnson
Period: September 2002 to October 2008
Funding: $2,283,044
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: Work under this contract is completed. The final Report to Congress is proceeding through clearance processes (as of February 2008).

Description: The objective of the evaluation is to assess the effectiveness of disease management programs for serious chronic medical conditions, such as advanced stage diabetes and congestive heart failure. Although the participating demonstration sites may vary by classification of disease severity, the availability of a pharmacy benefit, population targeted, scope of patient care covered, type of comparison group and other factors, they will have in common the goal of improving quality and reducing cost of health care received by chronically ill Medicare beneficiaries through specific services targeted to the management of a particular medical condition. The evaluation will assess the effectiveness of the disease management programs in improving quality and health outcomes and reducing costs. ■

Evaluation of Rural Community Hospital Demonstration

Project No: HHSM-500-2006-00006I/06
Project Officer: Linda Radey
Period: August 2007 to October 2011
Funding: $562,464
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The Draft Evaluation Design report was received by CMS and comments were sent to contractor in November of 2007.

Description: This project will evaluate the impact of the Rural Community Hospital Demonstration. The demonstration is examining effects of changes in Medicare reimbursements on the financial measures of small rural hospitals. Financial measures include financial viability and spending patterns. The contractor will also determine the benefits to the community and whether the hospitals reached their goals. Nine rural hospitals are enrolled in the demonstration for five years. CMS will reimburse demonstration hospitals at 100 percent of cost for inpatient care or a target amount, whichever is lower. The impact analysis will use Hospital Cost Reports Information System (HCRIS), the fiscal intermediary or MAC reconciliation of hospital cost report data during the demonstration period to estimate the change in Medicare reimbursements due to the demonstration. The case study evaluation component will examine issues pertaining to the implementation and operational experiences of the participating hospitals, using semi-annual reports filed by the demonstration hospitals and interviews with hospital officials. ■

Evaluation of Second Phase of Oncology Demonstration Program

Project No: HHSM-500-2006-00009I/02
Project Officer: Pauline Karikari-Martin
Period: August 2006 to August 2008
Funding: $654,447
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is its second year of funding.

Description: This task order will evaluate how oncologists and hematologists adapted their practice in response to the CMS payment incentive, and to understand lessons learned for future demonstration projects involving oncologists and all specialists. The contractor will be requred to design and conduct the evaluation of this demonstration. The evaluation will include collecting and analyzing primary and secondary data to examine issues that pertain to participation in this demonstration and system changes made within

the physician office. Primary data will be collected from three sources: focus groups, site visits and formal surveys. Secondary data will come from the CMS claims/billing system. This evaluation project offers a unqiue opportunity to capitalize on a nationwide demonstration, which involves data collection on how physician practices respond to financial incentives to collect and report data which is not normally collected on the claim form. ■

Evaluation of the Cancer Prevention and Treatment Demonstration

Project No: 500-00-0024/27
Project Officer: Karyn Anderson
Period: September 2005 to September 2010
Funding: $1,929,624
Principal Investigator: Janet Mitchell
Award: Task Order
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The enrollment period for the demonstration began October of 2006 across three sites: Detroit, Hawaii and Utah/Montana. Enrollment began one month later for Newark and Baltimore sites. Enrollment at the Houston site began in April of 2007.

As of January 15, 2008, 4443 individuals have enrolled in the demonstration with a total of 4144 in the screening arm and 299 in the treatment arm. In both the screening and treatment arms of the study, the numbers were roughly equivalent across the intervention and control groups. At the Detroit site, a total of 2587 participants have been enrolled, with 2408 in the screening arm and 179 in the treatment arm. At the Newark, NJ site, a total of 491 participants have been enrolled; 447 and 44 were enrolled in the screening and treatment arms respectively. Across the participating Indian reservations in Utah and Montana there are 487 total enrollees with all 487 in the screening arm; no treatment arm participants have been enrolled at this site to date. In Baltimore, with 477 total participants, the vast majority (473) have been enrolled in the screening arm and only 4 individuals have been enrolled into the treatment arm. The Houston site enrolled a total of 215 individuals, with 156 and 59 in the screening and treatment arms, respectively. At the Hawaii site, 186 total participants have been recruited, with 173 in the screening arm and 13 in the treatment arm.

The evaluation is well underway. All final six sites visit reports have been received. The first Report to Congress has been submitted to CMS ahead of schedule and is due September 2008. The final Report to Congress is due to Congress September 2010.

Description: The contractor will analyze the experience of the intervention group in each demonstration site compared to the relevant comparison group and to the relevant Medicare population-at-large by addressing such issues as the elimination or reduction of disparities in cancer screening rates, timely facilitation of diagnostic testing, timely facilitation of appropriate treament modalities, use of health services, the cost-effectiveness of each demonstration project, the quality of services provided, and beneficiary and provider (e.g., patient navigators/case managers/treatment facilitators as well as clinical staff) satisfaction. Six demonstration sites have received awards (Baltimore, Detroit, Hawaii, Houston, Newark, and a Rocky Mountain location). The task order contract will be funded in four, one-year phases: Phase One (September 30, 2005 - September 29, 2006); Phase Two (September 30, 2006 - September 29, 2007); Phase Three (September 30, 2007 - September 29, 2008); and Phase Four (September 30, 2008 - September 29, 2009). Phase I and Phase II are currently funded. ■

Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare

Project No: 500-00-0031/07
Project Officer: Carol Magee
Period: September 2005 to September 2009
Funding: $1,553,273
Principal Investigator: William B. Stason
Award: Task Order
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Phase one of the contract ended in September 2007. Phase two has begun and another $372,132 was allocated to the funding. A Report to Congress in is preparation.

Description: This Task Order is to assess the feasibility and advisability of expanding the coverage of chiropractic services under the Medicare program. The evaluation shall be conducted to: 1) Determine

whether diagnostically 'eligible' beneficiaries who avail themselves of the expanded chiropractic services within the four demonstration treatment regions (i.e., 'users') utilize relatively lower or higher amounts of items and services for which payment is made under the Medicare program, than do comparison beneficiaries with approved NMS diagnoses treated medically within the respective control regions; 2) Determine the regional, overall, and service-specific costs for such expansion of chiropractic services under the Medicare program; 3) Ascertain the satisfaction, perceived functional status, and concerns of eligible beneficiaries receiving remibursable chiropractic services in the treatment regions; 4)Determine the quality fo the expanded chiropractic care received, based upon outcomes that can be derived from claims data; 5)Evaluate "...such other matters at the Secretary determines are appropriate...", which, within this contract, shall include determination of whether the demonstration achieved budget neutrality for the aggregate costs for beneficiaries with chiropractic-eligible NMS diagnoses, as well as the amount of any resultant savings or deficit to the Medicare program.

Seven months into the Evaluation contract, Brandeis had completed site visits/interviews with the four demonstration regional CMS claims carriers, as well as with the respective American Chiropractic Association chapters. The OMB package for the proposed mailed satisfaction survey of 2,000 beneficiary recipients of expanded chiropractic services across the 4 demonstration regions was put into the 6-month review circulation for OMB approval in February 2006. OACT has just reviewed and approved, without revision, the contractor's proposal for the budget neutrality determination, as contained within the drafted Design Report. Currently underway is finalization of plans for impending selection of the 4 control regions and for the analysis of Medicare Claims data. ■

Evaluation of the Demonstration to Maintain Independence and Employment (DMIE) and Other Related Disease-Specific 1115 Waiver Programs

Project No: 500-00-0046/02
Project Officer: Susan Radke
Period: September 2001 to September 2007
Funding: $1,238,055
Principal Investigator: Susan Haber
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Status: Enrollment in the District of Columbia (DC) Ticket-to-Work Demonstration was at its maximum (approximately 400 persons) and an evaluation involving analysis of claims data and focus groups, to address the issues described in the above paragraph, was conducted by the contractor. Enrollment in the DC 1115 program began in January 2005 and the enrollment in the Mississippi Ticket-to-Work demonstration was below targeted levels and the evaluation was scaled back. A modification of the contract included secondary data analyses meant to enhance the understanding of efforts to forestall progression to full disability status. The contract has now ended and the contractor provided a final invoice to CMS for all costs incurred under this task order.

Description: This project evaluates several demonstrations providing supplemental Medicaid benefits to persons with HIV/AIDS who, in the absence of such benefits, may undergo a decline in functional status or be unable to gain employment or remain employed as a result of inadequate medical and ancillary care for their illness. The evaluations will assess the association between enhanced Medicaid eligibility and health care costs; changes in employment status, health status, and quality-of-life; and other factors. The demonstrations allow States to assist working individuals by providing the necessary benefits and services required for people to manage the progression of their conditions and remain employed and allow the Centers for Medicare & Medicaid Services to assess the impact of the provision of Medicaid benefits on extended productivity and increased quality of life. The demonstrations provide States the opportunity to evaluate whether providing such workers with early access to Medicaid services delays the progression to actual disability. ■

Evaluation of the Erickson Advantage CCRC Demonstration

Project No: HHSM-500-2006-00010I/0001
Project Officer: David Skellan
Period: August 2006 to August 2008
Funding: $375,564
Principal Investigator: Andrea Ptaszek
Award: Task Order (XRAD)
Awardee: Pacific Consulting
PO Box 42026
Palo Alto, CA 94306

Status: The contractor has completed site visits and focus group meetings at three Erickson sites - headquarters at Charlestown in Catonsville, MD;

Brooksby in Peabody, MA; and Ann's Choice in Warminster, PA. Subsequent site visit and focus group reports were produced for internal CMS use. The contractor has begun the secondary data analysis portion of the contract. This analysis will address the key research questions of the project, and interim findings will be presented to CMS staff at a December 2007 meeting.

Description: This task order will evaluate the Erickson Advantage Continuing Care Retirement Community (CCRC) demonstration in Erickson Retirement Communities. The purpose of the demonstration is to expand the range of the innovative health plans available to Medicare beneficiaries with a significant burden of chronic illness. The lessons learned from this demonstration will help CMS to establish criteria for Medicare Advantage (MA) plans for residents of CCRCs or other similar residential facilities for Medicare beneficiaries. These criteria would need to distinguish CCRC-based Medicare Advantage plans whose fundamental purpose is to improve care for beneficiaries with significant progressive chronic health problems from those plans whose goals is simply to limit enrollment to a relatively affluent population that does not have distinctive health needs. The evaluation of the Erickson Advantge CCRC demonstration will address a variety of analytic issues using a combination of primary and secondary data. Primary data will be collected through focus group interviews and site visits. ■

Evaluation of the Illinois and Wisconsin State Pharmacy Assistance Programs

Project No: 500-00-0031/02
Project Officer: William Clark
Period: September 2002 to August 2007
Funding: $1,199,885
Principal Investigator: Donald Shepard
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The contract has ended and a final report has been delivered.

Description: This evaluation examines two State pharmacy programs that have expanded Medicaid pharmacy coverage to low income residents otherwise not Medicaid eligible. The goals of this project are to understand administrative issues regarding State-sponsored prescription drug benefit program and to estimate the cost effectiveness of providing prescription drug coverage to elderly beneficiaries. Specifically, it will conduct a descriptive evaluation, a cost-effectiveness analysis, and other analyses of specific aspects of the Illinois and Wisconsin pharmacy plus waiver demonstrations. The evaluation also provides an opportunity to assess pharmacy coverage for large numbers of Medicare beneficiaries as a precursor to Medicare prescription drug coverage, and changes in State programs that are made in adjusting to the new Medicare role. ■

Evaluation of the Informatics, Telemedicine, and Education Demo - Phase II

Project No: HHSM-500-2004-00022C
Project Officer: Carol Magee
Period: September 2004 to September 2008
Funding: $970,711
Principal Investigator: Lorenzo Moreno
Arnold Chen
Award: Contract
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The demonstration is ending. The Final RTC will summarize findings over the 8-year demonstration, including up to 6 years of patient telemedicine follow-up for the two temporal cohorts.

Description: This contract for a second 4-year evaluation (Phase II, 2004 - 2008) of the IDEATel telemedicine diabetes demonstration (both of which were extended by the MMA 2003 into a Phase II, covering an additional 4 years) is essentially a follow-up of the evaluation done during Phase I of IDEATel, 2000-2004 (under the BBA 1997). Please refer to the Phase I evaluation contract (# 500-95-0055, TO 5) for background information.

This Phase II evaluation will not only cover the 4 years of IDEATel's Phase II progress and outcomes between 2004 and 2008, but will also provide summary evaluation results across the entire 8 years of the demonstration's existence. ■

Evaluation of the Inhalation Drug Therapy Demonstration

Project No: HHSM-500-2005-00018I/03
Project Officer: Steve Blackwell
Period: September 2006 to September 2010
Funding: $450,000
Principal Investigator: Andrea Hassol
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project is ongoing.

Description: This task order will evaluate the Inhalation Drug Therapy Demonstration. The purpose of the demonstration is to test whether the provision of care management/care coordination services by inhalation drug suppliers leads to improvements in beneficiary health status and lower overall Medicare program costs. It is reasonable to hypothesize that the added support services provided by participating inhalation drug suppliers for the beneficiaries they serve will improve compliance with the prescribed inhalation drug regimen which, in turn, will lead to appropriate and regular use of inhalation drugs, and lower Medicare costs associated with physician office visits, emergency room visits and inpatient hospital stays. As such, the evaluation of the demonstration shall consist of an independent overall evaluation of the project and its impact on health outcomes and beneficiary and physician satisfaction.

At the present time, the work addressed in Task VIII of the contract is being conducted. Task VIII is titled, "Exploratory Research on Medication Therapy Management (MTM)." This task is being conducted to help inform CMS decision making about MTM and specifically to help CMS identify and understand attributes of MTM programs that may be most effective for the Medicare Program including: the organization types providing MTM; the services and interventions included; the providers involved; how beneficiaries are targeted; the differences from and integration with disease management (DM) programs; the financial structures; and resultant outcomes. To answer these questions an information scan and case studies of Medication Therapy Management Programs (MTMPs) in the public and private sectors will be conducted. ■

Evaluation of the Medical Adult Day-Care Services Demonstration

Project No: 500-00-0031/05
Project Officer: Susan Radke
Period: September 2005 to September 2009
Funding: $821,916
Principal Investigator: Walter Leutz
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Brandeis University is completing the final part of phase one. Site visits to all five demonstration sites were conducted. The contractors met with administrators, staff, demonstration participants, and those who refused to participate in the demonstration. Utilizing information from the beneficiary face-to-face interviews, Brandeis is currently drafting a satisfaction survey for phase two of the study that will be submitted to OMB under the Paperwork Reduction Act. The contractor is now beginning phase two activities which includes the bulk of the quantitative analysis.

Description: The purpose of this task order is to conduct the Evaluation of the Medical Adult Day-Care Services Demonstration. Under this demonstration, which was mandated by Section 703 of the Medicare Modernization Act of 2003, Medicare beneficiaries who qualify for the Medicare home health benefit will be allowed to receive a portion of their home health nursing and therapy services in a medical adult day care facility, instead of their home. In September 2005, a task order was awarded to Brandeis University, Institute for Health Policy to conduct the evaluation.

This task order consists of three phases. Phase 1 will last 18 months and will include finalization of the evaluation plan, most of the qualitative analyses, and preliminary activities related to the quantitative analysis. Phase 2 will follow immediately after Phase 1 and will last for 30 months. The bulk of the quantitative analysis is expected to be done during Phase 2, at the end of which the Final Report will be delivered to CMS. Finally, Phase 3 will consist of an optional, extended period of 12 months, during which the task holder will remain available to make revisions to the Report to Congress as required during the Federal review process and address inquiries as needed. ■

Evaluation of the Medicare Care Management for High Cost Beneficiaries Demonstration

Project No: 500-00-0024/25
Project Officer: David Bott
Period: September 2005 to March 2009
Funding: $1,784,544
Principal Investigator: Nancy McCall
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Preliminary data are being reviewed.

Description: The purpose of this project is to design and initiate the evaluation of the "Care Management for High Cost Beneficiaries" (CMHCB) demonstration programs as implemented in the Medicare program. The six awarded demonstration sites implement and operate a care management demonstration serving high-cost beneficiaries in the original Medicare fee-for-service (FFS) program.

CMS contracted with RTI, Inc. to study the design and implementation of these programs and to evaluate the experience of the intervention group in each program compared to the relevant control group to ascertain the ability of each program and individual elements of each program to improve clinical quality, achieve high levels of beneficiary and provider satisfaction, promote efficient use of health care services, and produce savings for Medicare in the intervention group. Under this contract the evaluator shall assist CMS to assure that a suitable control group is identified and to design and execute the specific evaluation plan. ■

Evaluation of the Medicare Care Management Performance Demonstration (Phase I)

Project No: 500-00-0033/05
Project Officer: Lorraine Johnson
Period: September 2004 to September 2008
Funding: $1,030,970
Principal Investigator: Lorenzo Moreno
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The period of performance was extended to September 2008. All other terms and conditions remain unchanged and in effect.

Description: The purpose of this project is to evaluate the effectiveness of the Medicare Care Management Performance (MCMP) Demonstration as mandated by section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The Contractor was required to design and conduct the evaluation of this demonstration. The evaluation includes a comprehensive case study component to examine issues pertaining to the implementation and operational experiences of the participating practices. The Contractor was required to conduct various statistical analyses of secondary data, including individual level data, to examine issues related to quality of care and impacts on the use and costs of services. Primary data arer being collected through interviews of key personnel at participating practices, and interviews with beneficiaries and physicians. ■

Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration

Project No: 500-00-0024/05
Project Officer: Penny Mohr
Period: September 2002 to March 2008
Funding: $2,545,139
Principal Investigator: Gregory Pope
Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The final report on the PPO demonstration plan offerings and enrollment has been submitted. This report addresses three key outcomes of the PPO demonstration: availability of PPOs, plan offerings, and enrollment. In addition, a final report on the beneficiary survey results was submitted and approved. The survey analysis

focused on three main questions central to understanding the demonstration:

- Do beneficiary characteristics vary by plan type?
- What factors affect beneficiary plan choice?
- How do beneficiary experience and rating of health care vary by plan type?

The contract was modified to extend the period of performance through March 31, 2008. All other terms and conditions remain unchanged and in effect.

Description: The purpose of this project is to evaluate the Medicare Preferred Provider Organization (PPO) demonstration. This comprehensive evaluation includes a case study component to examine issues pertaining to the implementation and operational experiences of the PPOs as well as statistical analyses of secondary data, including individual level data, to examine issues of biased selection and impacts on the use and cost of services. Primary data is being collected through site visits to participating plans and a beneficiary survey. ■

Evaluation of the Part D Payment Demonstration

Project No: 500-00-0024/23
Project Officer: Aman Bhandari
Period: September 2005 to June 2008
Funding: $995,434
Principal Investigator: Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The evaluation design was submitted and approved. In addition several reports have been completed including the "Medicare Part D Payment Demonstration Site Visit Report" and the "Medicare Part D Payment Demonstration Focus Group Report", both of which have been posted on the CMS Web site.

Description: This project focuses on evaluating the impact of the Medicare Part D payment "reinsurance" demonstration. CMS has announced its intent to conduct a demonstration that represents an alternative payment approach for private plans offering prescription drug coverage under Part D. The demonstration is expected to increase the number of offerings of supplemental prescription drug benefits through enhanced alternative coverage. The purpose of this demonstration was to "allow private sector plans maximum flexibility to design alternative prescription drug coverage."

This evaluation examines the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs), and Medicare program costs. From the beneficiary perspective, the evaluation focuses on the availability of, and enrollment in, enhanced alternative benefit packages offered by drug plan sponsors, as well as enrollees' patterns of utilization. The evaluation also explores the advantages and disadvantages of participation from the perspective of drug plan sponsors and the Medicare program (Federal Register, Vol. 70, No. 37). Both primary (site visits, focus groups) and secondary CMS data sources are being used in the evaluation of this demonstration. ■

Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration

Project No: 500-00-0033/01
Project Officer: Fred Thomas
Period: September 2001 to June 2008
Funding: $2,452,864
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: Evaluation work on permanent PACE is near completion; as of January 2008, the Report to Congress is under review by the Department of Health and Human Services. The Report on for-profit PACE is not feasible at this time due to a lack of providers and data. A supplemental report on a community-based practice model was completed during 2006 and is available on the Web site at http://www.cms.hhs.gov/reports/downloads/cheh.pdf.

Description: This project is an evaluation of the Program for All-inclusive Care for the Elderly (PACE) as a permanent Medicare program and as a State option under Medicaid. The project evaluates PACE in terms of site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data and other comparable populations. This project expands on the foundations

laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment and assessing the impact of higher end-of-life costs and long-term nursing home care. ■

Evaluation of the Rural Hospice Demonstration

Project No: 500-00-0026/04
Project Officer: Linda Radey
Period: September 2005 to September 2010
Funding: $832,045
Principal Investigator: Jean Kutner
Andrew Kramer
Cari Levy
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The contract consists of two phases. Contract funds have been awarded for Phase I and Phase II. The Evaluation is currently underway. The contract was modified to revise the scope of work and the level of effort as a result of a reduction in the available funding. Selected tasks currently listed under Option Phase III shall be moved to Option Phase II.

Description: The purpose of this project is to evaluate the impact of the Rural Hospice Demonstration on changes in the access and cost of care, and to assess the quality of care for Medicare beneficiaries with terminal diagnoses who reside in rural areas but lack an appropriate caregiver. Two rural hospice facilities enrolled in the demonstration, which will last up to five years. Under the demonstration, CMS will reimburse hospices for the full range of care provided within their walls. CMS will also waive the 20-percent inpatient day cap for beneficiaries in the demonstration, and the requirement that the hospice must provide care in the community for one of the hospices in the demonstration. Evaluation tasks include monitoring the progress of the demonstration, and preparation of case studies and impact analyses using secondary data. Evaluation results will be incorporated into a report to the Congress when the demonstration ends. ■

Evaluation of the State Child Health Insurance Program

Project No: 500-96-0016/03
Project Officer: Susan Radke
Period: July 1999 to January 2007
Funding: $4,256,094
Principal Investigator: Margo Rosenbach
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The national evaluation is complete and the final report entitled: "National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access" can be found on the CMS Web site at

http://www.cms.hhs.gov/reports/downloads/Rosenbach9-19-07.pdf.

Description: CMS contracted with Mathematica Policy Research, Inc. (MPR) to conduct a national evaluation of SCHIP and assist CMS with its report to Congress (Rosenbach et al., 2003). The CMS national evaluation of SCHIP contains several components: (1) analysis of SCHIP enrollment, d isenrollment, and reenrollment patterns based on the SCHIP Statistical Enrollment Data System (SEDS) and the Medicaid Statistical Information 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 care based on the state SCHIP annual reports; (5) analysis of outreach and enrollment effectiveness using quantitative and qualitative methods; (6) a case study of program implementation in eight states; and (7) analysis of SCHIP performance measures. Several states have recently proposed or implemented new strategies to expand health insurance coverage for children beyond SCHIP. The CMS national evaluation of SCHIP does not examine these initiatives because it was beyond the scope of the project. ■

Evaluation of the Use of Bedside Technology to Improve Quality of Care in Nursing Facilities

Project No: 500-00-0024/10
Project Officer: Renee Mentnech
Period: January 2003 to December 2006
Funding: $820,388
Principal Investigator: Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The project is complete. A final report is available.

Description: The Centers for Medicare & Medicaid Services (CMS) has awarded a contract to Research Triangle Institute, the University of Missouri Sinclair School of Nursing, and OneTouch Technologies to evaluate the use of hand-held technology in nursing homes. This project will examine the use of bedside technology to collect daily measures of resident care and outcomes in nursing facilities (NFs). The application of this new technology could be useful for improving the efficiency and effectiveness of care in these facilities. The specific objectives of the project include: (1) Evaluating whether the use of bedside data collection with portable computer devices, automated processes, and electronic medical records technology improves collection of daily measures of resident care in NFs. (2) Evaluating whether the use of this technology improves outcomes of care in NFs. (3) Evaluating whether patient outcomes are enhanced by coupling the use of bedside technology with on-site clinical consultation by expert nurses. ■

Evaluation of Wheel Chair Purchasing in the Consumer-Directed Durable Medical Equipment (CD-DME) Demonstration and Other Fee-For-Service and Managed Care Settings

Project No: 500-00-0032/06
Project Officer: Ann Meadow
Period: September 2002 to November 2007
Funding: $419,501
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: A case study report on the first year of project implementation has been accepted. The demonstration has ended. The contractor prepared reports on other DME coverage issues pertaining to mandated consumer service standards mandated in the Medicare Modernization Act of 2003.

Draft standards were presented to the Program Advisory Oversight Comittee, during an open door forum, and posted on the CMS Web site for a 60-day public comment period. More than 5,000 commenters responded to the draft standards. The draft standards are being revised based on public comments and will be published through CMS program instructions.

In the project's late stages, the early accreditation program which CMS set up was examined. The evaluation's standards were used as a basis for creditation. The project is now complete.

Description: The purpose of this task order is to conduct a preliminary case-study evaluation of a four-site initiative. The descriptive evaluation will compare and contrast the purchasing of wheelchair equipment in these sites with those utilized in fee-for-service and in managed care models which serve people with disabilities. The study will propose further evaluation design options for CMS consideration and related feasibility studies of other DME. This initiative tests, at a local level, an important collaboration between the Department of Health and Human Services and the Department of Education intended to improve beneficiary access and satisfaction with the purchase and maintenance of wheelchair equipment.

Section 1834(a) of the Social Security Act as amended by Section 302 of the Medicare Modernization Act of 2003 requires the Secretary to establish quality standards for DMEPOS suppliers to be applied by accreditation organizations. In June 2005, this contract was modified

based on findings from the evaluation and to meet the needs of this statute. This modified scope of work, i.e., quality standards for specific durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), consistent with the original scope of work, will provide information of use to beneficiaries and advocacy groups, CMS, the Department of Education, States, health plan contractors, and community DMEPOS suppliers.

This additional task, developing service and quality assurance standards for specific DMEPOS items is also fundamental to consumer access to equipment that will be safely and appropriately used. These standards will assist the beneficiary to know what to expect from suppliers and what constitutes high quality service. Beneficiary education, a key feature of the scope of work in the current contract, is a fundamental aspect of the new task proposed in this modification. The assumption is that beneficiaries who are educated about the safe and proper use of their equipment will experience better outcomes with the equipment. This additional task continues the beneficiary involvement in the process of obtaining and appropriately using DMEPOS. ■

Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries

Project No: 500-00-0025/03
Project Officer: William Buczko
Period: September 2002 to December 2006
Funding: $649,958
Principal Investigator: Stephanie Maxwell
Timothy Waidman
Award: Task Order (RADSTO)
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Status: The Analytic Framework and Analysis Plan report was completed October 4, 2004 and is available on the ORDI Web site. This report includes: 1) detailed introduction and background on Medicare and long-term care spending and utilization; 2) conceptual frameworks of disability and service use; 3) extensive literature review regarding the determinants of long-term care utilization (nursing home, home care) and spend-down to Medicaid; and 3) three study cohorts for potential use in the project. The cohort discussions include statistical analysis plans, other methodological issues, file development, and criteria used in selecting the cohorts. The appendices include a review of home and community-based waiver programs and utilization.

Two cohorts were selected for quantitative analysis. The first is a forward-looking study of elderly whose first hospitalization for congestive heart failure (CHF) occurred in 1999. CHF is the most common discharge diagnosis for Medicare beneficiaries and has been shown to be a strong risk factor for death, rehospitalization, and functional decline. The analyses examine the course of CHF patients through the acute, post-acute, and long-term care systems from 1999 to 2003, and seek to identify the factors associated with patients' health, utilization, and cost trajectories through those systems. Medicare Part A and B claims, Medicare enrollment files, and MDS data are the key files used. The second cohort is a primarily forward-looking study of elderly whose first non-Medicare nursing home admission occurred in 1999. The analyses examine the Medicare and nursing home care utilization and costs following admission in 1999 through 2002 (the latest year of Medicaid data available), and the factors associated with the nursing home patient outcomes. Because of budget limitations and the use of Medicaid files in this analysis, the cohort is restricted to two States (Minnesota and New Jersey), chosen for geographic balance and Medicaid data quality. Medicare Part A claims, Medicare enrollment files, Medicaid claims, MDS data, and POS files are the key files used.

The analytic file development used 100% MDS files, 100% Medicare Part B files, and Medicaid files to create data files that would allow future projects to build on this study's research. The study files can be used to study additional research and policy issues, and the computer programs used to generate the files could be modified to create other data extracts and analytic files, such as other hospitalization cohorts and nursing home entrants in other States. The core SAS computer programs used to create the study files, including summary documentation describing the analytic file architecture, are part of the project's final deliverables.

The final report for the CHF cohort "Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries: A Longitudinal Analysis of Elderly Individuals with Congestive Heart Failure" was completed on February 27, 2007. The final report for the Nursing Home Entrants cohort "Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries: A Longitudinal Analysis of Elderly Individuals Entering Nursing Homes" was completed on May 11, 2007. The final reports for both cohort studies are available on the ORDI Web site.

Description: This project studies longitudinal patterns of care of elderly beneficiaries with likely long-term care needs and the progress of groups of beneficiaries with similar health/functional status who remain in the community or who move from the community to

institutional settings, as well as within institutional settings. It develops a research model and conduct studies based on this model to assess the progress of beneficiaries with similar medical conditions, functional status, and long-term care needs through the health-care delivery system. It addresses key factors influencing the delivery of care such as insurance coverage, types of services used, processes leading to institutionalization, and costs of care. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - Actuarial Research Corporation

Project No: HHSM-500-2006-00005I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $1,000
Principal Investigator: C. William Wrightson
Award: Task Order Contract, Base
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: This contract is an umbrella contract. Currently there are five (5) task orders issued under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These project will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - Acumen

Project No: HHSM-500-2006-00006I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $1,000
Principal Investigator: Thomas MaCurdy
Award: Task Order Contract, Base
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: This contract is an umbrella contract. Currently, there are ten (10) task orders awarded under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These projects will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - Impaq International

Project No: HHSM-500-2006-00007I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $1,000
Principal Investigator: Sharon Benus
Award: Task Order Contract, Base
Awardee: Impaq International LLC
10420 Little Patuxent ParkwaySuite 300
Columbia, MD 21044

Status: This is an umbrella contract. Currently there are two (2) task orders issued under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These projects will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - Kennell and Associates, Inc.

Project No: HHSM-500-2006-00008I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $1,000
Principal Investigator: David Kennell
Award: Task Order Contract, Base
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: This is an umbrella contract. Currently there are two (2) task orders issued under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These projects will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - L&M Policy Research

Project No: HHSM-500-2006-00009I
Project Officer: Leslie Mangels
Period: April 2006 to April 2011
Funding: $1,000
Principal Investigator: Lisa Green
Award: Task Order Contract, Base
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: This is an umbrella contract. Currently there are six (6) task orders awarded under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These projects will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Expedited Research and Demonstration (XRAD) Task Order Contract - Pacific Consulting Group

Project No: HHSM-500-2006-00010I
Project Officer: Leslie Mangels
Period: April 2006 to April 2011
Funding: $1,000
Principal Investigator: Ellen McNeil
Award: Task Order Contract, Base
Awardee: Pacific Consulting
PO Box 42026
Palo Alto, CA 94306

Status: This is an umbrella contract. Currently there is one (1) task order awarded under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These project will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

Family or Individual Directed Community Services (FIDCS) Research

Project No: HHSM-500-2006-00006I/09
Project Officer: Suzanne Bosstick
Period: September 2007 to September 2010
Funding: $248,523
Principal Investigator: Ursula Bischoff
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The project is underway.

Description: Self-direction continues to grow in numerous ways, including the number of waivers offering self-direction, the number of individuals who

may avail themselves of self-direction and scope of self-direction that States make available. More than 32 States have incorporated self-direction into their 1915(c) Home and Community Based Services (HCBS) waivers. With the passage of Deficit Reduction Act of 2005 (DRA), States have an additional vehicle which they can employ to offer HCBS to individuals who are aged and individuals who have disabilities. This task will provide States with individual technical assistance and information to determine the vehicle that best will meet their needs and those of the individuals they wish to serve. The technical assistance will assist States to design and implement participant directed programs that comport with all applicable Federal and State guidelines. The Contractor, through the scenarios encountered during State specific technical assistance activities, will identify areas requiring systemic guidance. Additionally, the contractor may provide technical assistance to CMS staff as requested by the Project Officer. The contractor will provide CMS with a report of activities, trends, and findings at the end of the contract period. ■

Federal-State Health Reform Partnership

Project No: 11-W-00234/02
Project Officer: Camille Dobson
Period: September 2006 to September 2011
Funding: $0
Principal Investigator: Deborah Bachrach
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Corning Tower Building
Albany, NY 12237

Status: The State has completed implementation of mandatory managed care for low income families in the 14 upstate counties. Expansion of mandatory managed care to SSI recipients continues across the State. Implementation is complete in New York City, while Nassau, Suffolk, Onandaga, Oswego, and West Chester Counties will begin mandatory enrollment by the end of 2007.

Description: The Federal-State Health Reform Partnership (F-SHRP) Demonstration provides authority to mandate managed care enrollment for beneficiaries receiving SSI or who otherwise are aged or disabled, requires recipients in low-income families (AFDC-related) in 14 upstate counties to enroll in mandatory managed care, provides federal matching funds for designated state health programs, and requires the State to implement reforms to promote the efficient operation of the State's health care system. The demonstration is funded by savings generated from mandatory managed care enrollment for the SSI population. ■

Florida Consumer Directed Care Plus Demonstration (formally Cash and Counseling Demonstration)

Project No: 11-W-00117/04
Project Officer: Melissa Harris
Period: October 1998 to February 2008
Funding: $0
Principal Investigator: Danielle Reatherford
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive
Tallahasee, FL 32308

Status: CMS approved this demonstration to operate without the experimental treatment/control group design, and to offer self-direction on a Statewide basis. This new phase of the demonstration, now called Consumer Directed Care Plus (CDC+) has been operational since January 1, 2004.

Description: The purpose of this demonstration is to provide greater autonomy to consumers of long-term care services by empowering them to purchase the assistance they require for daily life. Demonstration participants are provided a monthly cash allowance, which they use to select and purchase the Personal Assistance Services (PAS) they need. Fiscal and counseling intermediary services are available to assist participants with managing budgets. Other partners in this collaborative effort include the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, and the National Program Office at the University of Maryland Center on Aging, which performs various coordinating functions. ■

Florida Medicaid Reform

Project No: 11-W-00206/04
Project Officer: Mark Pahl
Period: October 2005 to June 2011
Funding: $0
Principal Investigator: Thomas Arnold
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive
Tallahasee, FL 32308

Status: The Florida Medicaid Reform demonstration was approved October 19, 2005 and implemented July 1, 2006. The State initially implemented Reform in Broward and Duval Counties, then expanded to Baker, Clay and Nassau Counties July 1, 2007. Further expansion is pending approval by the Florida legislature.

Description: Under Florida Medicaid Reform, a greater proportion of the State's Medicaid population are moving into managed care environments. Participation is mandatory for TANF related populations and the aged and disabled with some exceptions. The demonstration allows managed care plans to offer customized packages, although each plan must cover all mandatory services. The demonstration provides incentives for healthy behaviors, allows beneficiaries to opt out of Medicaid to take advantage of employer sponsored insurance, and established a low-income pool to support coverage to the uninsured. Services are provided through health maintenance organizations and provider service networks. The primary objectives are to increase the number of health plan choices for beneficiaries, increase access to services and providers, and increase access to the uninsured. ■

Formative Research and Product Testing of MMA Communications

Project No: 500-00-0037/06
Project Officer: Alissa Schaub-rimel
Period: September 2004 to December 2006
Funding: $835,655
Principal Investigator: Barbara Allen
Kate Heinrich
Barbara Cohen
Award: Task Order (RADSTO)
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

Status: The project has been completed.

Description: The goal of this project encompasses not only beneficiary needs for accessible, high-quality health care and the prompt, accurate processing of health claims, but also the beneficiary needs for information about program benefits, appeal rights, health plans, provider choices, treatment options, and more. Specific activities include: formative research and/or product testing about health plan decisionmaking, a new Medicare Preferred Provider Organization (PPO) benefit pamphlet, an assessment of the Guide to Medicare's Provider Services publication, and three other similar tasks yet to be developed. ■

Geographic Variation in RX Drug Spending

Project No: HHSM-500-2006-00006I/02
Project Officer: Jesse Levy
Period: August 2006 to August 2008
Funding: $185,971
Principal Investigator: Grecia Marrufo
Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The project is ongoing.

Description: This Task Order, mandated under Section 107(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) will analyze Medicare Part D Data to examine the extent of geographic variation in per capita drug spending, and whether that variation is attributable to prices or differences in utilization. Findings from this research will inform a Report to Congress, due January 1, 2009, about whether it is appropriate to include a geographic adjustment factor in Medicare's payment to Part D plans The study includes an optional task that will analyze the impact of a geographic adjuster on Medicare's direct subsidies to Part D plans, if wide geaographic variations are found. ■

Global Commitment to Health

Project No: 11-W-00194/01
Project Officer: Jacqueline Roche
Period: September 2005 to September 2010
Funding: $0
Principal Investigator: Joshua Slen
Award: Waiver-Only Project
Awardee: Vermont Department of Social Welfare, Office of Health Access, Agency of Human Services
312 Hurricane Lane, Suite 201
Williston, VT 05495

Status: On October 31, 2007, CMS approved the State's September 11, 2006, amendment request to enable the State to implement the employer sponsored insurance (ESI)/Catamount Health Program. Under this approval, Vermont has the authority to provide premium assistance for adults with income up to 200 percent of the Federal poverty level (FPL). According to Vermont's projections, incorporating expenditures for the ESI/Catamount premium assistance initiative will cost approximately $30 million.

Description: Through the Vermont Global Commitment to Health Demonstration, the Office of Vermont Health Access (OVHA) operates as a public Managed Care Organization (MCO). OVHA receives a monthly capitation payments from its parent agency (the Vermont Agency of Human Services), and is at risk for all services (other than long-term care services) required by covered populations. These capitation payments form the basis for Vermont's claim of title XIX matching funds. All title XIX matching funds provided under Global Commitment to Health are subject to a five-year aggregate budget neutrality expenditure limit of $4.7 billion. ■

Hauula Community Diabetes Screening Program, The

Project No: 18-P-92309/09-01
Project Officer: Pauline Karikari-Martin
Period: September 2004 to March 2007
Funding: $987,317
Principal Investigator: Charman Akina
Award: Grant
Awardee: Waimanalo Health Center
41-1347 Kalanianaole Highway
Waimanalo, HI 96795

Status: This project has ended. Only $555,367 of the total funding for the project was used and $431,950 was unobligated. The project started slow and had many challenges. A final report has been submitted and an article of the grants findings is scheduled to be published in the Hawaii Medical Journal. The title of the article will be "Communicating Health Information and Encouraging Behavioral Change in Isolating Populations".

Description: This grant will provide outreach, awareness, and diabetes and cardiovascular disease screening, as well as relevant health educational and behavioral intervention services, to the geographically isolated, mostly-Samoan community of Hauula, (population 3,651) on Oahu. To date, 675 people have had diabetes and cardiovascular disease screening. Educational newsletter mailings on diabetes and cardiovascular diseases were sent to 1,907 physical addresses in February 2006. ■

Hawaii QUEST Expanded

Project No: 11-W-00001/09
Project Officer: Diane Gerrits
Lane Terwilliger
Period: July 1993 to June 2008
Funding: $0
Principal Investigator: Lois Lee
Award: Waiver-Only Project
Awardee: Hawaii Department of Human Services, Med-Quest Division

P. O. Box 700190
Kapolei, HI 96709-0190

Status: The Demonstration is scheduled to expire on June 30, 2008. The State has requested a 5-year extension under section 1115(a) authority that would also allow them to incorporate the aged, blind and disabled Medicaid populations into a new managed care program called QUEST Expanded Access (QExA). They also propose making adjustments to FPL eligibility thresholds. The request for extension with amendment is pending.

Description: Hawaii's QUEST Expanded Demonstration extends Medicaid coverage to additional children and adults, through the creation of a public purchasing pool that arranges for health care through

capitated managed care plans. This demonstration builds upon the Hawaii Prepaid Health Care Act, an Employee Retirement Income Security Act (ERISA) wavier, which requires all employers to provide insurance coverage to any employee working more than 20 hours per week. Title XIX funded coverage is offered to several groups who are not eligible under the Medicaid State Plan, including TANF cash recipients who are otherwise ineligible for Medicaid and childless adults, with incomes up to 100% of FPL. Expanded title XIX coverage is funded through savings from managed care, and the reallocation of funds formerly used to provide payment adjustments to disproportionate share hospitals. SCHIP-eligible children also receive their coverage through the delivery system created by QUEST Expanded. ■

Hawaii Rural Health Interdisciplinary Training Demonstration Project

Project No: 144514
Project Officer: James Coan
Period: July 2006 to June 2008
Funding: $990,000
Principal Investigator: Ronald Schurra
Award: Grant
Awardee: Hawaii Health Systems Corporation
3675 Kilauea Avenue
Honolulu, HI 96818

Status: The Grant was awarded May 17, 2006. Work began July 1, 2006 and will conclude June 30, 2008.

Description: The focus of this project is to develop interdisciplinary, collaborative and culturally appropriate family medicine residency, nursing and allied health professions training in rural Hawaii, with a goal of reducing health disparities and improving access to culturally appropriate care for native Hawaiians and underserved populations. Hawaii is a state that is geographically isolated and has an uneven distribution of physicians and health care providers. Most are clustered around tertiary care hospitals in Honolulu. Medical education and health professions training sites likewise are largely limited to O'ahu with the exception of associate-level nursing programs in the community college system. Thirty percent of the population are scattered on the remaining isolated and rural neighbor islands. Native Hawaiians represent 20% of the population, and carry a disproportionate burden of disease. For example, Native Hawaiians have rates of type II diabetes that are four times higher than the US standard population, and mortality rates from diabetes eight times that of non-Hawaiians. Failure to address these disparities will lead to significant health care costs for the state and federal governments in the future.

This project relies on a development of a partnership between the Hilo Medical Center and community and the University of Hawaii Department of Family Medicine and Community Health. They plan to develop an ACGME-accredited three year Rural Family Medicine training program that emphasizes Native Hawaiian health. This program will catalyze a broader interdisciplinary training collaborative to develop culturally-appropriate and accessible care, as well as community-appropriate strategies for training nursing, social work, nutrition and other allied health professionals. The focus will be on improving hospital-community collaboration and team care for Native Hawaiians and underserved persons with chronic illness in order to reduce health disparities. ■

HBCU: Colorectal Cancer Screening

Project No: 20-P-92383/04-02
Project Officer: Richard Bragg
Period: September 2004 to May 2007
Funding: $250,000
Principal Investigator: Joan Wilson
Award: Grant
Awardee: Alabama Agricultural and Mechanical University
P.O. Box 411
Normal, AL 35762

Status: The project is completed.

Description: The purpose of this study is to identify and establish effective intervention strategies that will result in changes in attitudes and behaviors involving the utilization of health care services by a population that is at high risk for colorectal cancer. The study will provide effective training and psychologically-based educational activities to promote screening and early detection for colorectal cancer in African American men and women. The objectives are to: (1) deliver an education intervention about the incidence and mortality rates and other factors responsible for the racial/ethnic disparity of colorectal cancer, (2) increase the knowledge about colorectal cancer, (3) strengthen positive attitudes toward the health care system and medical professionals, (4) increase the number of participants receiving colorectal screening, and (5) reduce personal/psychological barriers

limiting access to the health care system for colorectal cancer screening. ■

Health Insurance and Access to Care Among Social Security Disability Insurance Beneficiaries in the 24-Month Waiting Period for Medicare

Project No: ORDI-IM-2006-00002
Project Officer: Gerald Riley
Period: January 2005 to January 2007
Funding: $0
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The results of this study were published in the Fall 2006 issue of *Inquiry*. The abstract of the article is as follows:

Abstract

For most Social Security Disability Insurance (SSDI) beneficiaries, Medicare entitlement begins 24 months after the date of SSDI entitlement. Many may experience poor access to health care during the 24-month waiting period because of a lack of insurance. National Health Interview Survey data for 1994-1996 were linked to Social Security and Medicare administrative records to examine health insurance status and access to care during the Medicare waiting period. Twenty-six percent of SSDI beneficiaries reported having no health insurance, with the uninsured reporting many more problems with access to care than insured individuals. Access to health insurance is especially important for persons in the waiting period because of their low incomes, poor health, and weak ties to the workforce.

Riley GF. Health insurance and access to care among Social Security Disability Insurance beneficiaries during the Medicare waiting period. Inquiry. Vol. 43, No. 3 pp. 222-230. Fall 2006.

Description: For most Social Security Disability Insurance (SSDI) beneficiaries, Medicare entitlement begins 24 months after the date of SSDI entitlement. Many may experience poor access to health care during the 24-month waiting period because of a lack of health insurance. National Health Interview Survey data for 1994-1996 were linked to Social Security and Medicare administrative records to examine health insurance status and problems with access to care during the Medicare waiting period. The study examined percentages of SSDI beneficiaries with and without insurance, sources of insurance, factors associated with lack of insurance, and access problems reported by those with and without insurance. ■

Healthier Mississippi

Project No: 11-W-00185/04
Project Officer: Mark Pahl
Period: September 2004 to September 2009
Funding: $0
Principal Investigator: Robert L. Robinson
Award: Waiver-Only Project
Awardee: Mississippi, Office of Governor, Division of Medicaid
Robert E. Lee Building, 239 N. Lamar St., Suite 801,Hinds County
Jackson, MS 39201

Status: The Healthier Mississippi demonstration was implemented October 1, 2006 and will run through September 30, 2009.

Description: The Healthier Mississippi demonstration provides coverage for beneficiaries previously served under the Poverty Level Aged and Disabled (PLAD) category of eligibility. This optional Medicaid eligibility group was eliminated from the State plan in 2004. Children receive Medicaid State plan benefits and adults receive a modified benefit package. Services are delivered through the State's fee-for-service provider network. The objective of the demonstration is to provide a continuation of services for certain PLAD beneficiaries who in the absence of the demonstration, would in time likely become eligible for Medicaid at a greater cost to the State. ■

Home Health Datalink File--Phase III

Project No: HHSM-500-2004-00153G
Project Officer: Ann Meadow
Period: September 2004 to April 2009
Funding: $479,999
Principal Investigator: Edward Fu
Award: Inter-agency Agreement

Awardee: Fu Associates
2300 Clarendon Boulevard, Suite 1400
Arlington, VA 22201

Status: Under the direction of CMS, the contractor conducted data analyses to refine specifications for the analytic files. In January 2005, the contractor delivered a 100 percent file of home health PPS payment episodes through June 2004 with detailed edited and derived variables summarizing utilization and payment information internal to the claim. Additional variables summarize information from external sources, including inpatient claims files, enrollment data, Area Resource File data, and Provider of Service File variables. The episodes are uniquely linked to several ancillary files containing details on related inpatient stays, OASIS and other patient assessments, and other information. The files are being used in several intramural and extramural studies and evaluations in CMS and DHHS. An update of the file with additions and enhancements was delivered in 2006. Specifications for adding additional linked files are under development. The contract has been extended to April 2009.

Description: The Balanced Budget Act of 1997 mandated dramatic changes in several areas of Medicare services, including the home health benefit. The Act mandated a home health prospective payment system (PPS), to be preceded by an interim payment system (IPS) until the PPS could be implemented. In place from late 1997 to October 2000, the IPS led to sharp reductions in numbers of home health agencies and home health utilization by Medicare beneficiaries. Policymakers will want information on the full impact of this succession of changes. Therefore, data development for such studies is needed by the Department and will be in demand by external researchers and policymakers. Under this project, the contractor annually provides a comprehensive, data-analytic file covering the entire PPS period to date. The file serves the medium-term needs of policymakers regarding the Medicare home health benefit. In addition, the file will meet the internal needs of CMS and the Department in the areas of payment refinements, quality improvement, and program integrity. The contractor is also tasked with providing certain technical assistance and analytical programming support using the products of the contract. This project is a continuation of a data development effort originally begun in 2000 by CMS; it is currently funded in part by the Office of the Assistant Secretary for Planning and Evaluation under Interagency Agreement Number IA-04-133. ■

Home Health Demonstrations: Technical Support

Project No: 500-00-0032/09
Project Officer: Bertha Williams
Period: July 2004 to February 2009
Funding: $1,331,399
Principal Investigator: Henry Goldberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The 2-year Home Health Independence Demonstration was implemented beginning October 4, 2004 and ended October 4, 2006. The Medical Adult Day Services Demonstration was implemented in five sites on August 1, 2006 and will end August 1, 2009.

Description: The purpose of the Home Health Demonstrations Technical Support contract is to assist CMS with the design, implementation, and operation of two home health demonstrations mandated under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The first is the Demonstration Project to clarify the Definition of Homebound, mandated under Section 702 of the MMA. IN this demonstration, Medicare beneficiaries with permenant, debilitating disabilities who met specific criteria were allowed to receive needed home care and leave home as often and as long as they wished and still be considered homebound. Three states were selected for the demonstration, Missouri, Colorado and Massachusetts. All home health agencies in these states were eligible to participate in the demonstration.

The second demonstration, the Medical Adult Day Care Services Demonstration was mandated under Section 703 of the MMA. In this demonstration home health agencies are permited to provide beneficiaries with the option of receiving a portion of their needed home care in a medical adult day care facility. The demonstration was restricted to the selection of 5 sites, i.e. home health agencies, in states that license or certify medical adult day care facilities. ■

Home Health Independence Demonstration

Project No: ORDI-05-0004
Project Officer: Armen Thoumaian
Claudia Lamm
Period: October 2004 to October 2006
Funding: $900,000
Principal Investigator: Henry Goldberg
Deborah Deitz
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The demonstration was implemented October 4, 2004 in Colorado, Massachusetts, and Missouri. Abt Associates is the implementation contractor for the demonstration. The demonstration ended October 3, 2006 with total enrollment only reaching 58 beneficiaries (Colorado 22, Massachusetts 7 and Missouri 29). The evaluation report is due October 2007.

Description: Section 702 of the MMA states that the Secretary shall conduct a 2-year demonstration in three States (representing the Northeast, the Midwest, and the West). Medicare beneficiaries with chronic conditions of a specific nature are deemed to be homebound, without regard to purpose, frequency, or duration of absences from home, for the purpose of receiving home health services under the Medicare Program. Enrollment under the demonstration is limited to no more than 15,000 beneficiaries. ■

Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00018I/04
Project Officer: James Coan
Period: September 2006 to March 2009
Funding: $542,231
Principal Investigator: Henry Goldberg
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The contractor developed a detailed Home Health Pay for Peformance Demonstration design, which CMS has implemented. Recruitment of home health agencies began October 5, 2007. Implementation of the demonstration will begin January 1, 2008.

Description: The purpose of this Task Order is to provide assistance to CMS in the design and implementation of the Home Health Pay-for-Performance Demonstration. The contractor will examine various pay-for-performance models and an appropriate and feasible design for the Home Health Pay-for-Performance Demonstration. This Task Order has an optional Phase II, which if exercised would extend the period of performance by 18 months. ■

Home Health Third Party Liability Demonstration Arbitration

Project No: HHSM-500-2005-00033I
Project Officer: Juliana Tiongson
Period: September 2005 to September 2008
Funding: $763,000
Principal Investigator: S. Paret
Award: Contract
Awardee: American Arbitration Association
601 Pennsylvania Avenue, NW
Washington, DC 20004-2676

Status: CMS has obtained legal representation during the arbitration hearings. Hearings covering Fiscal Year 2001 cases are scheduled to begin in December 2007.

Description: CMS has entered into individual agreements with the State Medicaid agencies of Connecticut, Massachusetts, and New York to operate a demonstration program to determine the Medicare payment of certain home health services provided to certain individuals. If any one of the States or its agents is dissatisfied with CMS's determination of Medicare coverage for these claims, the parties have agreed to utilize arbitration services. The American Arbitration Association (AAA) contractor shall perform arbitration services for Home Health Third Party Liability Demonstration. ■

Impact of Care Coordination and Support Strategic Partnership on Health Care Use of Chronically and Seriously Ill Patients and Improved Use of Community Services and Program Satisfaction of their Caregivers, The

Project No: 18-P-93113/3-01
Project Officer: Pamela Morrow
Period: July 2005 to December 2006
Funding: $248,000
Principal Investigator: Theresa Kisiel
Award: Grant
Awardee: Hamot Medical Center
3330 Peach Street, Suite 211
Erie, PA 16508

Status: After a 6 month extension, this project ended on December 31, 2006.

Description: The objectives of the project are to determine the impact of care coordination and support strategic partnerships (CCSSPs) on (1) decreasing emergency department visits, acute care admissions and length of stay, nursing home admissions and length of stay in chronically and seriously ill patients; (2) improving use of community services by caregivers of chronically and seriously ill patients; (3) caregiver satisfaction with CCSSP service delivery; and (4) effectiveness in addressing specific care giving problems. ■

Impact of Increased Financial Assistance to Medicare Advantage Plans

Project No: 500-00-0024/17
Project Officer: Melissa Montgomery
Period: August 2004 to April 2009
Funding: $1,199,931
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

Status: The Report to Congress is on the CMS Web site. It is located here:

http://cms.hhs.gov/Reports/Downloads/Pope.pdf

Description: Section 211(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Secretary of Health and Human Services report to Congress, no later than July 1, 2006, on the impact of additional funding provided under MMA and other Acts including the Balanced Budget Refinement Act of 1999 and the Beneficiary Improvement and Protection Act of 2000 on the availability of Medicare advantage (MA) plans in different areas and the impact on lowering premiums and increasing benefits under such plans. The purpose of this project is to develop and implement a monitoring system with key indicators of health plan performance. Key indicators both nationwide and within market areas will be used to support the report to Congress required by section 211(g) of the MMA.

Originally, this contract was to be completed in late 2005; however, in 2006 extensive program-wide changes (e.g., regional plans, competitive programs, and Part D drug benefit) were implemented concurrently. As a result, it became necessary to exercise the contract option in order for the contractor to continue to monitor the MA program. Resulting in the period of performance being extended to 2009. Forthcoming are reports for 2006, 2007, and 2008. ■

Impact of Payment Reform for Part B Covered Outpatient Drugs and Biologicals

Project No: 500-00-0033/09
Project Officer: Iris Wei
Period: June 2005 to June 2009
Funding: $1,333,834
Principal Investigator: Valerie Cheh
Arnold Chen
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Contractor's technical proposal entitled "Impact of Payment Reform for Part B Covered Outpatient Drugs and Biologicals" and it's revisions were incorporated by reference and made a part of the task order. Additionally, the contractor has submitted and presented two annual reports except that the second report is still under revision.

Description: This study will assess 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 study will cover a broad array of drugs and physician specialties and analyze the effects of the payment reforms over the time period 2004-2007. While the focus will be on the payment reform for drugs currently covered under Part B, the study will need to consider other provisions of the MMA that might affect the utilization of these drugs.

The contractor is responsible for designing and carrying out the study, including the collection and analysis of primary and secondary data. ■

Impacts Associated with the Medicare Psychiatric PPS

Project No: 500-00-0024/18
Project Officer: Fred Thomas
Period: September 2004 to June 2008
Funding: $839,772
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

Status: A report on psychiatric co-morbidities has been released and is on the CMS Web site. The project received a no-cost extension and will now run until June 2008.

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. ■

Implementation & Evaluation of the Physician Group Practice Demonstration; Additional Support for the Implementation of the Medicare Care Management Performance (MCMP) Demonstration

Project No: 500-00-0024/13
Project Officer: Jody Blatt
Period: September 2003 to September 2008
Funding: $4,494,082
Principal Investigator: Michael Trisolini
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: In FY 2008 the work related to the PGP demonstration was shifted to a new contract. Work for the MCMP demonstration will continue under this contract through September 28, 2008.

Practices will be eligible for an incentive for reporting baseline data which was completed in January, 2008. Incentive payments are expected to be issued in early spring 2008. The first pay for performance year will be based on data from the first full demonstration year (July 2007-June 2008). That data will be collected in late fall 2008.

Description: This contract was originally awarded in 2003 to support the implementation and evaluation of the Physician Group Practice(PGP) Demonstration, Medicare's first pay-for-performance initiative for physicians in large multi-specialty group practices.

In 2005, the contract was modified to incorporate clinical quality measure data collection and related tasks for the Medicare Care Management Performance (MCMP) Demonstration, a pay for performance demonstration for smaller primary care group practices in four states (Arkansas, Utah, California, & Massachusetts). The MCMP demonstration was authorized under section 649 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. The goal of this demonstration is to improve the quality of care for chronically ill Medicare beneficiaries while encouraging the implementation and adoption of health information technology by primary care physicians. Under this demonstration, physician groups will receive financial incentives based on performance on 26 clincical quality measures related to the care of beneficiaries with diabetes, congestive heart failure, coronary artery disease, and preventive care services. In addition, they

will be eligible to earn additional bonuses if the quality measure data is submitted electronically from a CCHIT-certified electronic health record. The demonstration began July 1, 2007 with almost 700 practices and will run through June 30, 2010. ■

Implementation and Monitoring, Support of the Medicare Hospital Gainsharing Demonstration

Project No: HHSM-500-2006-00005I/03
Project Officer: Lisa Waters
Period: August 2006 to August 2010
Funding: $1,792,012
Principal Investigator: David McKusick
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The project is now fully funded.

Description: This demonstration will provide a test of gainsharing in the Medicare program. It will determine if gainsharing can align the incentives between hospitals and physicians in order to improve the quality and efficiency of care. The goal is to improve hospital quality, while focusing on operational and financial performance. The contractor will provide overall implementation and monitoring support for the three year demonstration. All data collected and analyzed for real-time monitoring will subsequently be used for the evaluation; therefore the contractor will collaborate with the evaluation contractor to collect and store all data elements. The contractor shall be responsible for monitoring gainsharing arrangements to ensure all demonstration requirements are met. The contractor shall monitor the quality of care throughout the demonstration to ensure that the gainsharing arrangements do not compromise the quality of patient care in any way. Through data collection and analysis, the contractor shall determine whether internal hospital efficiency has improved as a result of the demonstration. The contractor shall closely monitor Medicare payments to determine whether the demonstration is resulitng in an overall reduction of Medicare spending, or has the unintended consequence of leading to an increase in spending such as a shifting of costs from inpatient to post-acute care or ancillary services. The contractor shall monitor admission and referral patterns at participating hospitals and neighboring hospitals to ensure that not significant or detrimental changes ocur as a result of the demonstration. The implementation/monitoring contractor shall work closely with the evaluation contractor to compliment each others work and avoid unnecessary duplication of tasks. ■

Implementation of Consumer Assessments of Health Plans Disenrollment Survey

Project No: 500-01-0018/01
Project Officer: Amy Heller
Period: September 2003 to April 2007
Funding: $4,349,537
Principal Investigator: W. Sherman Edwards
John Rauch
Award: Task Order (ADDSTO)
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: The project is complete.

Description: The Centers for Medicare & Medicaid Services (CMS) is an active participant in the CAHPS (Consumer Assessment of Health Plans) effort—-a cooperative agreement headed by the Agency for Health Care Research and Quality to develop standardized instruments and reporting formats for providing comparative information to aid consumers in making more informed health plan choices. The core CAHPS survey instrument developed for the adult commercial population is currently used to assess the care provided by health plans covering over 123 million Americans. In 1997, CMS sponsored the development of a Medicare version of the CAHPS survey for enrollees (hereinafter referred to as the Medicare Managed Care CAHPS Survey (MMC-CAHPS)). CMS has just completed the seventh annual nationwide administration of MMC-CAHPS. CMS has funded three different Medicare versions of the CAHPS surveys to assess beneficiaries' experiences and ratings of care within the Medicare Program—Medicare+Choice (M+C) Assessment Survey, M+C Disenrollee Survey and the Fee-for-Service (FFS) Survey.

Medicare CAHPS Disenrollment Survey: There are two different disenrollment surveys. In the fall of 2000, CMS began to conduct a separate annual survey of beneficiaries who voluntarily disenrolled from M+C organizations to gather information about their experiences with the plan they left. This survey is known as the Medicare CAHPS Disenrollment Assessment Survey. Results from the Disenrollment Assessment Survey are combined with those from the Enrollee

Survey for reporting to the public and to plans. Reporting the information in this way provides a more accurate account of all Medicare beneficiaries' experiences with M+C organizations. CMS added the survey results from disenrollees to the overall survey results to ensure that positive survey results were not the result of CMS' continuous enrollment policy. References to the MMC-CAHPS survey refer to the combination of the MMC-CAHPS Enrollee Survey and the Disenrollment Assessment Survey. Westat conducts this portion of the disenrollmet survey.

CMS also sponsors the Medicare CAHPS Disenrollment Reasons Survey. The purpose of the Reasons Survey is to collect data about the reasons why Medicare beneficiaries leave their M+C health plans. Although data from the Reasons Survey are analyzed on an annual basis, sampling and data collection are conducted on a quarterly basis. The Reasons Survey has been conducted for CMS each year since 2000 and survey results can be found on Medicare's website, www.Medicare.gov, through Medicare Health Plan Compare and Medicare Personal Plan Finder. RT conducts this portion of the disenrollment survey. ■

Implementation of ESRD Bundled Payment and Pay-for-Performance

Project No: HHSM-500-2006-00005I/02
Project Officer: Henry Bachofer
Period: August 2006 to August 2008
Funding: $498,862
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The MMA §623(e) demonstration is on hold pending the finalization of the Report to Congress called for by MMA §623(f).

Description: The purpose of this Task Order is to assist CMS in the implementation of a demonstration project on the use of pay-for-performance (P4P) methods for providers of services to beneficiaries with End Stage Renal Disease (ESRD). ■

Implementation of the Physician Group Practice Demonstration

Project No: HHSM-500-2005-00029I/07
Project Officer: John Pilotte
Fred Thomas
Period: September 2007 to September 2010
Funding: $1,729,948
Principal Investigator: Gregory Pope
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Currently, the demonstration is in its third performance year. The next Report to Congress is scheduled for December 2008.

Description: The PGP Demonstration is the first pay-for-performance initiative for physicians under the Medicare program. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the demonstration rewards physicians for improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population.

Under the demonstration, physician groups continue to be paid under regular Medicare fee schedules and may share in savings derived care management programs and quality improvement initiatives focusing on Medicare fee-for-service patients. Physician groups may earn performance payments of up to 80% of the savings they generate. The Medicare Trust Funds retain at least 20% of the savings. Performance payments are divided between cost efficiency for generating savings and performance on 32 ambulatory care quality measures, focusing on common chronic conditions and preventive care, phased in during the demonstration.

At the end of the first performance year, all participating physician groups improved the clinical management of diabetes patients. All 10 of the groups achieved benchmark or target performance levels on at least seven of the ten diabetes clinical quality measures and eight physician groups increased their scores on six or more diabetes quality measures.

In addition, two physician groups earned performance payments for quality and cost efficiency of $7.3 million as their share of the $9.5 million in savings to the Medicare program. Additional groups had lower Medicare spending growth rates than their local

markets during the first year of the demonstration but not sufficiently lower to share in savings under the demonstration's performance payment methdology. ■

Implementation Support and Evaluation for the Medicare Health Care Quality Demonstration (MMA Section 646)

Project No: HHSM-500-2005-00029I/01
Project Officer: Cynthia Mason
Period: September 2005 to September 2011
Funding: $2,003,591
Principal Investigator: Michael Trisolini
Award: Task Order
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Site specific demonstration designs are under development.

Description: The contractor will assist with the determination of payment rates. The contractor will also assist in the design and implementation of a system of site-specific, quality based goals for distribution of bonus payments. ■

Implementation Support for Health System Payment Reform Demonstration Proposals and Related Demonstrations

Project No: 500-00-0033/12
Project Officer: Juliana Tiongson
Period: September 2005 to September 2010
Funding: $698,719
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contract was modified to increase the level of effort along with the funding by $225,000. The period of performance was extended to September 2010.

Description: The contractor shall provide technical assistance in developing, refining and implementing Health System Reform and related demonstrations. The contractor shall provide seven waiver cost estimates for a variety of Health System Payment Reform and related demonstrations over a 24 month period. ■

Implementation Support for the Inhalation Drug Therapy Demonstration

Project No: HHSM-500-2006-00005I/01
Project Officer: Maria Sotirelis
Period: August 2006 to February 2008
Funding: $0
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The status of the project is pending OMB approval. THe contract was modified to extend the Base period of performance through February 29, 2008.

Description: The Centers for Medicare & Medicaid Services (CMS) plans to implement a demonstration project in six states that will measure the value of care management/care coordination activities provided by large suppliers of inhalation therapy drugs to Medicare beneficiaries who use respiratory medications administered by nebulizers under Medicare Part B. This contractor will assist CMS in its effort to impelement the demonstration. ■

Implementation Support for the Quality Incentive Payment of the ESRD Disease Management Demonstration

Project No: 500-00-0028/03
Project Officer: Siddhartha Mazumdar
Henry Bachofer
Period: September 2004 to September 2008
Funding: $2,180,974
Principal Investigator: Frederich Port, M.D.
Award: Task Order (RADSTO)

Awardee: Arbor Research Collaborative for Health formerly known as URREA (University Renal Research and Education Association)
315 West Huron, Suite 260
Ann Arbor, MI 48103

Status: Arbor Research (formerly URREA) has developed clinical measures for determining the Quality Incentive Payment and has implemented data transfers for the 3 participating demonstration organizations. The organizations began enrolling ESRD patients early in 2006. Arbor Research has conducted the first two semi-annual reconciliations, determining the quality incentive payment for the organizations.

Description: The purpose of this project is implementation support for the Quality Incentive Payment of the ESRD Disease Management Demonstration and implementation and support for an Advisory Board for the ESRD Bundled Case-Mix Adjusted Demonstration, mandated by Section 623(e) of MMA. ■

Implementation, Monitoring, and Support of the Physician Hospital Collaboration Demonstration

Project No: HHSM-500-2006-00005I/04
Project Officer: Lisa Waters
Period: August 2007 to August 2011
Funding: $689,088
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The final approval process for this demonstration project is underway.

Description: This demonstration project will provide a test of gainsharing in the Medicare program. It will determine if gainsharing can align incentives between hospitals nad physicians in order to improve the quality and efficiency of care. The goal is to improve hospital quality, hwile focusing on operational and financial performance. The Contractor will provide overall implementationa nd monitoring support for the 3-year demonstration. The implementation/monitoring contractor shall work closely with the evaluation contractor to compliment each others work and avoid unnecessary duplication of tasks. CMS plans to award a separate contract to an organizatin for the purpose of evaluating the Physician Hospital Collaboration Demonstration. ■

Implementing the HEDIS Medicare Health Outcomes Survey

Project No: HHSM-500-2004-00015I/01
Project Officer: Sonya Bowen
Chris Haffer
Period: September 2004 to September 2008
Funding: $2,753,271
Principal Investigator: Kristen Spector
Award: Task Order
Awardee: National Committee for Quality Assurance
1100 13th Street, NW
Washington, DC 20005

Status: The HOS is an ongoing annual survey. The HOS program has achieved national and international recognition as the largest collection of robust health status measurements from the patients' perspective in the world. Results have been presented at various national and international professional meetings and published extensively in peer-reviewed journals.

Description: The Medicare Health Outcomes Survey (HOS) is the only patient-based health outcome measure for the Medicare population. It was implemented in 1998. The survey is fielded nationally as a Healthcare Effectiveness Data Set (HEDIS) measure. It is a longitudinal, self-administered survey which utilizes the VR-12 health survey (assesses physical and mental functioning) and additional case mix adjustment variables. Each year, survey data are collected for a new sample (cohort) of Medicare managed care beneficiaries. Members that respond to the baseline survey are resurveyed 2 years later in a follow up. The goal of the Medicare HOS is to collect, valid, reliable, and clinically meaningful data that may be used to [1] monitor managed care performance in the Medicare Advantage program, [2] help beneficiaries make informed health care choices, [3] promote quality improvement based on competition, and [4] advance the state-of-the-science in health outcomes research. This project manages the collection and transmittal of the data to CMS and supports the technical development of the Medicare HOS measure. The survey is administered through a group of certified HOS vendors. ■

Improve Access to Primary Care and Preventive Services for Low Income and Uninsured Persons

Project No: 18-P-93130/5-01
Project Officer: Ellen Blackwell
Period: July 2005 to June 2007
Funding: $595,200
Principal Investigator: Thea Simmons
Thomas Cieszynski
Award: Grant
Awardee: City of Detroit
1151 Taylor, Room 249B
Detroit, MI 48202

Status: The City of Detroit and its partner in implementation, Southeastern Michigan Health Association, began implementation of the grant activities, consistent with the objectives set forth in their proposal.

Because of a delayed start to the project, the grantee was awarded a no-cost extension of the grant that allowed them to fully utilize funding in the manner intended. They made great strides in acquiring staff necessary to develop a sustainable infrastructure for the delivery of primary care services, to provide nursing care to homebound seniors, to improve access to transportation for primary services, to develop an age-appropriate oral health program for seniors, and to improve community outreach efforts.

They submitted an interim report to CMS on their project on April 1 (negotiated date due to the delayed start). A final report was requested from grantee on August 15, 2007.

Description: The mission of the Department of Health and Wellness Promotion (DHWP) is to effectively deliver preventive health services, improve access to primary care, and protect and promote health and social well-being through organized community action. This grant allows the DHWP to expand primary health care centers' abilities to maximize access to high quality services for Detroit's vulnerable and underserved communities. Specifically, the objectives of this project are to: develop a sustainable infrastructure for the delivery of primary care services; provide nursing care to homebound seniors; coordinate provision of transportation to increase accessibility of all primary care services; develop an age-appropriate oral health program for Detroit seniors age 55 and older; develop cross cutting community outreach efforts to facilitate consumer information, education, Medicaid enrollment and follow-up. ■

Improving Nursing Home Enforcement - Phase 2

Project No: 500-00-0026/03
Project Officer: Marvin Feuerberg
Period: September 2003 to September 2008
Funding: $2,393,163
Principal Investigator: Andrew Kramer
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: Workplans and some study designs for various tasks have been generated, analytic working files created, state promising practices briefs have been placed on CMS's website, and the case studies report is under final revision. The contractor's technical proposal has been delivered. The contract extended the period of performance to September 2008. Funsing has been increased by $314,997.

Description: This contract assesses the overall effectiveness of the current system of nursing home survey and certification quantitatively through a retrospective analysis of the impact of enforcement on resident outcomes. Overall effectiveness is also assessed qualitatively through prospective case studies on the impact of enforcement on provider care processes. In addition, a number of issues related to survey agencies' responses to complaints are examined to generate a more standardized system across States. The contract will be further modified in Fiscal Year 2005 to permit a thorough assessment of the key barriers and promising practices for improving the efficiency and effectiveness of State survey agencies. Finally, the contract was modified in April 2006 for analytic development of a method, based on survey data, for identifying poor performers that may require more survey attention and, as well, to identify other nursing homes that manifest higher qualtiy and may require less survey attention. ■

Improving Outcomes Using Medicare Health Outcomes Survey Data

Project No: GS-10F-0166/HHSM-500-2006-00001G
Project Officer: William Long
Period: November 2005 to February 2008
Funding: $2,386,972
Principal Investigator: Laura Giordano
Award: GSA Order
Awardee: Health Services Advisory Group
1600 East Northern Avenue, Suite 100
Phoenix, AZ 85020

Status: Round ten data submission, cleaning, and analysis from the 2007 HOS field administration will be completed in early 2008. Cohort eight performance measurement and cohort ten baseline results will be finalized and made available later in 2008. Fiscal Year 2008 activities will also include comparative analyses between the Medicare managed care and fee-for-service populations on differential health status, health care utilization and expenditures, and care satisfaction.

Description: CMS contracts with the Health Services Advisory Group to conduct annual data cleaning, scoring, analysis, and performance profiling of Medicare Advantage (MA) (formerly Medicare + Choice) plans for the Medicare Health Outcomes Survey data collection; to educate MA plans and Quality Improvement Organizations (QIOs) in the use of functional status measures and best practices for improving care; and to provide technical assistance for QIOs and plan interventions designed to improve functional status. The contractor also produces special reports, public use data files, analytical support, and consultative technical assistance using HOS baseline and follow-up data, supplemented by other data sources, to inform CMS program goals and policy decisions. ■

Improving Prostate Cancer Screening Rates Among African-American Men in Rural Black Belt Counties in Alabama: An Education Intervention Program

Project No: 20-P-92379/04-02
Project Officer: Richard Bragg
Period: September 2004 to September 2007
Funding: $250,000
Principal Investigator: Vivian Carter
Award: Grant
Awardee: Tuskegee University
College of Veterinary Medicine Nursing and Allied Health Kresge Center
Tuskegee, AS 36088

Status: This project is under the HBCU Health Services Research Grant Program. The project is in progress and there have been no cost extensions.

Description: The purpose of the study is to develop and evaluate the effectiveness of a prostate cancer education program on prostate screening rates among African-American men aged 40 and over in the rural settings of two Alabama "Black Belt" counties (Macon and Bullock). Prostate cancer is the second leading cause of cancer deaths in these communities. The objectives are to: (1) Determine through focus groups barriers to routine screening for prostate cancer among African American men in the Macon and Bullock County Areas; (2) Increase the knowledge of African-American men and women about prostate cancer, through a health education program, as measured by pre- and post-tests; (3) Increase the number of African-American men who participate in regular prostate cancer screening; (4) Develop prostate cancer screening follow-up activities to determine the number and percentage of men that engage in prostate screening after the education intervention. ■

Improving the Accuracy and Consistency of the Nursing Home Survey Process - Evaluation of Quality Indicators in the Survey Process (QIS)

Project No: 500-00-0032/07
Project Officer: Jean Scott
Period: September 2003 to June 2008
Funding: $1,737,772
Principal Investigator: Alan White
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The 5-State demonstration began in September 2005 and consisted of surveys of record conducted by two survey teams in each of the 5 States. The evaluation results have been very positive; the QIS is very likely to replace the current survey. However, it has not been subject to a summative evaluation: how well the QIS meets the objectives of improving the current survey within the current survey budget is unknown. A contract modification was awarded in August 2006 will provide funds for the second, summative phase of the evaluation's field work. The period of performance was extended to June of 2008.

The very substantial variation in deficiency citation rates and scope and severity determinations between States, within States, and from year-to-year has been widely noted as evidence of inconsistency in the survey. A corollary perception is that this inconsistency indicates that the survey is not accurate. Of course, providers tend to view the inconsistency and inaccuracy as evidence that the survey process is capricious and citation rates are too high. In contrast, this inconsistency is viewed by the advocates as evidence that survey agencies are too lax and more enforcement is needed. In either case, confidence in the survey is undermined.

Description: The original purpose of this contract was to improve the accuracy and consistency of the current nursing home survey. During the first year of the contract it became clear that an entirely new survey process - Quality Indicators in the Survey Process (QIS) - had reached a developmental point that it could replace the current survey. Given the emergence of the QIS as a real possibility, it did not make sense to direct the contract to improving the current survey when this survey is likely to be replaced by a fundamentally very different survey, the QIS. The original RFP anticipated this as a possibility. Hence, the contract has been modified to evaluating this new QIS survey.

The variability in the number and the scope and severity of deficiencies has been a long-standing concern both to the advocates and the nursing home industry. In addition, the survey has been criticized as an inaccurate reflection of the actual quality of care. To meet these concerns, CMS has developed under contract an entirely new process utilizing quality indicators, the QIS. This development process has been very extensive, lasting over six years and over five million in resources. This new process is intended to improve accuracy, consistency, and documentation for identified deficiencies. The beta tests indicate that the new process appears feasible and an improvement compared to the current system. The purpose of this contract is to conduct an independent evaluation of this new process under realistic conditions of actual implementation in 5 pilot States over a 12-month period. ■

Increasing Access to Health Care for Bucks County Residents

Project No: 18-P-91506/03
Project Officer: Carol Magee
Period: September 2001 to September 2008
Funding: $3,339,750
Principal Investigator: Sally Fabian
Award: Grant
Awardee: Bucks County Health Improvement Project, Inc.
1201 Langhorne-Newton Rd
Langhorne, PA 19047

Status: In September 2005, at the request of the grantee and stemming from unanticipated delays in implementation, the project was granted a no-cost extension to run through September 9, 2006. Supplemental funds were awarded in September 2006 to fund the project through September 2008. The 2007 annual report is due in December 2007.

Description: The project is entirely directed toward increasing access to health care for targeted vulnerable populations. Five of the Bucks County Health Improvement Project programs are already operating and will expand services to include patients in need of dental network, medication assistance, State Children's Health Insurance Program (SCHIP) outreach, adolescent mental health counseling, and influenza vaccination. A sixth program will be a new service facility comprised of two community health care clinics for low-income adults and seniors in the lower county area. Together, these six new or expanded program services will target vulnerable

subgroups of all ages. Quantitative and descriptive data are to be collected. This service-delivery expansion program is congressionally mandated. ■

Informatics for Diabetes Education and Telemedicine Demonstration (IDEATel)

Project No: 95-C-90998/06
Project Officer: Diana Ayres
Period: February 2000 to February 2008
Funding: $60,000,000
Principal Investigator: Steven Shea
Award: Cooperative Agreement
Awardee: Columbia University
630 West 168th St, PH 9 East, Room 105
New York, NY 10706

Status: In Phase I of the demonstration, the first 9 months of the project were devoted to technical implementation, field testing, personnel training, and development of the evaluation instruments and procedures. After enrollment began and recruitment was completed, approximately 1,665 beneficiaries were enrolled and randomized. Overall acceptability of the home telemedicine unit among participants was positive. During Phase II, second generation HTUs were developed, tested, and initial deployment begun to install them in the homes of participants. The experience to date indicates that large-scale home telemedicine as a strategy for disease management is technically feasible, can be performed in a fashion that meets current requirements for health care data security and the Health Insurance Portability and Accountability Act and is acceptable to those who agree to participate. Regardless, this does not preclude the extent of training and reinforcement often necessary under these circumstances to elevate enrollees to an active and participatory level. Evidence does indicate that some Medicare beneficiaries living in federally designated medically underserved areas, for reasons such as language barriers, lack of education, and various other socioeconomic indications, are unable or unwilling to use computers or the world wide web to obtain health care information and health care services.

Description: This project was mandated as a four year demonstration by Congress in the Balanced Budget Act of 1997. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress authorized an extension of the demonstration for an additional four years. The project focuses on Medicare beneficiaries with diabetes because of the high prevalence, cost, and complexity of this condition. It also focuses on beneficiaries living in federally designated, medically underserved areas in order to demonstrate that obstacles to bridging the "digital divide" in health care are not intrinsic to the targeted population. The project involves a consortium of health care delivery organizations in New York City (urban component) and upstate New York (rural component), industry partners who are providing hardware, software, technology, and communication services, and the American Diabetes Association, which is providing the educational web site for the project. The consortium is led by Columbia University. Intervention participants receive a home telemedicine unit (HTU) which facilitates uploading of clinical data, interaction with a nurse case manager, and patient education. ■

Inpatient Rehabilitation Facility Classification System Analytic and Programming Support

Project No: HHSM-500-2006-00039C
Project Officer: Susanne Seagrave
Period: September 2006 to September 2009
Funding: $419,840
Principal Investigator: David Malitz
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

Status: The Statement of Work was modified to eliminate Task 4 and renumber Task 5 to Task 4. It was also modified to provide incremental funding for increased effort.

Description: This contract will provide analytical and programming support to CMS in replicating and updating RAND's analyses associated with the IRF patient classification system. This contract will enable a translation of the RAND analysis logic such that the analysis and refinements to the IRF patient classification system recommended by RAND can be replicated, updated, and validated. As an extension of this work, this contract will also provide analytical and programming support to CMS to develop new payment policy approaches affecting the IRF patient population, to assess the impact of SNF resident population changes, and to update the IRF and SNF grouper methodology programming. ■

Integrated Payment Option Support Contract

Project No: 500-00-0024/06
Project Officer: J. Sherwood
Period: September 2002 to March 2008
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

Status: Several tasks under this contract were postponed and/or delayed. The contractor concentrated 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. The system covered services provided in inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies. The project was granted a six month no-cost extension in September 2007.

Description: This demonstration utilized 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 compared alternate methods for calculating payment rates using different assumptions such as co-morbid conditions, stage of diagnosis, and mix of services. ■

IowaCare

Project No: 11-W-00189/07
Project Officer: Juliana Sharp
Period: July 2005 to June 2010
Funding: $0
Principal Investigator: Eugene Gessow
Award: Waiver-Only Project
Awardee: Iowa Medicaid Enterprise,
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: The Demonstration is fully implemented. As of October 31, 2007, 20,025 expansion eligibles were served under the Demonstration.

Description: IowaCare expands health insurance coverage to uninsured Iowans up to 200% FPL, eliminates Medicaid financing arrangements whereby providers do not retain 100% of claimed expenditure, provides home and community-based services to children with chronic mental illness and moves towards community-based settings for delivering State mental health programs. The Demonstration uses an aggregate budget neutrality cap of $587.7 million. The aggregate cap was negotiated as a result of Iowa pledging to eliminate Medicaid financing arrangements whereby health care providers did not retain 100 percent of the claimed expenditure. The financing arrangements had yielded approximately $65 million in additional Federal funds annually for the State to use as its share of other Medicaid expenditures and non-Medicaid activities. ■

Kentucky Health Care Partnership Program

Project No: 11-W-00060/04
Project Officer: Mark Pahl
Period: December 1993 to October 2008
Funding: $0
Principal Investigator: Glenn Jennings
Award: Waiver-Only Project
Awardee: Kentucky Department for Medicaid Services
275 E Main Street, 6 E B
Frankfort, KY 40601

Status: On October 1, 2007, the State of Kentucky requested a three year extension of the Partnership demonstration. If approved, the extension will run from November 1, 2008 through October 31, 2011.

Description: The Kentucky Health Care Partnership is a sub-state demonstration that uses a single managed care plan model, including public and private providers, to deliver health care. The Partnership is a private non-profit entity that provides services for Medicaid beneficiaries in the city of Louisville in Jefferson County and the

fifteen surrounding counties. All non-institutionalized Medicaid beneficiaries are enrolled in the demonstration. Beneficiaries receive a comprehensive benefit package that corresponds to benefits and services available under the Medicaid State plan. Any willing provider may participate in the Partnership plan. The primary objective of the demonstration is to improve access to health care and needed services for beneficiaries, and to test the feasibility of providing services through a single managed care entity. ■

Legal Representation - Arbitration Hearings (Home Health TPL)

Project No: HHSM-500-2006-00047C
Project Officer: Juliana Tiongson
Period: September 2006 to September 2008
Funding: $751,915
Principal Investigator: Arthur Bruegger
Award: Contract
Awardee: Blue Cross/Blue Shield Association
225 N. Michigan Avenue
Chicago, IL 60601

Status: The period of performance has been extended to September 2008.

Description: This contract will perform services for the effort entitled "Legal Representation of the Centers for Medicare & Medicaid Services at Arbitration Hearings." This project was created so we will receive support in arbitration hearings for our Home Health projects. ■

Logistical Support to ESRD Bundled Case-Mix Adjusted Payment Demonstration Advisory Board

Project No: HHSM-500-2004-00003I/06
Project Officer: Pamela Morrow
Period: March 2005 to March 2008
Funding: $207,199
Award: Task Order
Awardee: Destiny Management Services, LLC
8720 Georgia Avenue
Silver Spring, MD 20910

Status: No meetings of the ESRD Advisory Board were held in 2007. CMS will continue to use this contractor when the next meetings are scheduled. Option Period II has been exercised.

Description: The contractor will execute Federal Advisory Committee Act (FACA) compliant public meetings, provide meeting support and services for CMS and the Advisory Board on the Demonstration of a Bundled Case-Mix Adjusted Payment System for ESRD Services members. ■

Long Term Care Hospital Payment System Refinement/Evaluation

Project No: 500-00-0024/20
Project Officer: Judith Richter
Period: September 2004 to September 2008
Funding: $931,021
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

Status: The contract was modified increase the level of effort to develop an instrument for establishing patient and facility level criteria for LTCHs.

Description: The contractor shall provide a wide variety of statistical data and policy analysis to evaluate the LTCH PPS and its effect on overall Medicare payments and also to determine the feasibility of CMS establishing facility and patient level criteria for LTCHs. ■

Low Vision Rehabilitation Demonstration

Project No: ORDI-05-0002
Project Officer: James Coan
Period: April 2006 to March 2011
Funding: $0
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The Low Vision Rehabilitation Demonstration project began on April 1, 2006 and run for 5-years. The demonstration is occurring in New Hampshire, greater New York City metroploitan area including all 5 boroughs, North Carolina, greater Atlanta metropolitan area, GA., Kansas, and Washington state.

Description: The Medicare Low Vision Rehabilitation Demonstration is an outpatient vision rehabilitation project in selected sites across the country. This project will examine the impact of standardized national coverage for vision rehabilitation services provided in the home by physicians, occupational therapists and certified low vision therapists, vision rehabilitation therapists, and orientation and mobility specialists. Under this Low Vision Rehabilitation Demonstration, Medicare will cover low vision rehabilitation services, in the home or in the doctors office, to people with a diagnosis of moderate or severe vision impairment not correctable by conventional methods of spectacles or surgery. ■

Maine Care for Childless Adults

Project No: 11-W-00158/01
Project Officer: Jacqueline Roche
Period: September 2002 to September 2010
Funding: $0
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Maine, Department of Human Services
11 State House Station
Augusta, ME 04333

Status: On September 28, 2007, the Demonstration was Approved for a three year renewal from October 1, 2007 through September 30, 2010. As of January 1, 2007, 20,000 childless adults received coverage under this Demonstration.

Description: This Demonstration extends coverage to childless adults and non-custodial parents with incomes up to 100 percent FPL. Funds that formerly were used to make payment adjustments to disproportionate share hospitals (DSH) are used instead to fund expanded coverage under the Demonstration. ■

Maine Medicaid Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS

Project No: 11-W-00128/01
Project Officer: Jacqueline Roche
Period: February 2000 to June 2010
Funding: $0
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Office of MaineCare Services (OMS)
11 State House Station
Augusta, ME 04333-0011

Status: On June 29, 2007, the Demonstration was approved for a three year renewal beginning July 1, 2007 through June 30, 2010. As of July 1, 2007, approximately half of the 556 total participants were Medicaid eligibles receiving enhanced care management services, while the rest were expansion eligibles who receive all of their coverage through the Demonstration.

Description: This Demonstration extends healthcare and prescription drug benefits to individuals with HIV/AIDS with incomes up to 250% of the FPL who are not otherwise eligible for Medicaid. Many of these individuals would eventually become disabled due to the natural progression of the disease, and eventually qualify for full Medicaid coverage. By providing a targeted package earlier in the process, the State hopes to slow the disease progress for persons living with HIV/AIDS and delay or prevent their becoming disabled. Savings from averted months of Medicaid eligibility are used to fund the expanded coverage. Individuals with HIV/AIDS who are currently eligible for Maine's Medicaid program may also enroll in the Demonstration to receive enhanced targeted case management services. ■

Maintain Independence and Employment Demonstration - Mississippi

Project No: 11-P-91175/04
Project Officer: Stephen Hrybyk
Period: October 2000 to December 2007
Funding: $500,000
Principal Investigator: Bo Bowen
Award: Grant

Awardee: Mississippi, Office of Governor, Division of Medicaid
Robert E. Lee Building, 239 N. Lamar St., Suite 801,Hinds County
Jackson, MS 39201

Status: The project is complete. Final evaluation completed by RTI and available from ORDI.

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration.

The Mississippi Project uses the grant award, in conjunction with State funds, to cover persons with HIV/AIDS who work or are willing to return to work. Full Medicaid benefits and services, as well as case management, is provided to the demonstration participants to ensure that they have access and coverage for medical, mental, and social support services necessary to maintain employment and their quality of life. The demonstration site is in nine counties in the Mississippi Delta where there is a relatively high rate of HIV/AIDS, and limited health care resources for people with HIV/AIDS. ■

Maryland Medicaid Section 1115 Health Care Reform Demonstration Proposal -HealthChoice

Project No: 11-W-00099/03
Project Officer: Diane Gerrits
Period: October 1996 to May 2008
Funding: $0
Principal Investigator: John Folkemer
Award: Waiver-Only Project
Awardee: Maryland, Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2793

Status: The State of Maryland sent a letter of intent to renew its HealthChoice Demonstration on May 16, 2007. As of December 1, 2007, CMS was awaiting an application package for the extension.

Description: Under the Maryland HealthChoice Demonstration, most Medicaid eligibles are required to receive their Medicaid coverage through capitated managed care plans. Savings from managed care are used to fund a variety of eligibility expansions. The following groups of individuals receive health care services under the Demonstration who do not qualify for coverage under the Medicaid State Plan: women losing Medicaid after a pregnancy-related period of eligibility (family planning service only), working individuals with disabilities with incomes up to 300 percent of FPL (full Medicaid benefits), individuals age 19 and over with income below 116 percent FPL and under $4,000 in assets (primary and preventive care, pharmacy, and outpatient mental health services), persons with income below 116 percent FPL who are not eligible for Medicare or SCHIP (pharmacy only), and persons age 65 and over with incomes up to 175 percent FPL and not participating in Medicare Part D (pharmacy only). The Demonstration also implements managed care for title XXI Medicaid expansion children. ■

MassHealth: Massachusetts Health Reform Demonstration

Project No: 11-W-00030/01
Project Officer: Jacqueline Roche
Period: April 1995 to June 2008
Funding: $0
Principal Investigator: Tom Dehner
Award: Waiver-Only Project
Awardee: Commonwealth of Massachusetts, Division of Medical Assistance
One Ashburton Place, 11th Floor
Boston, MA 02108

Status: The MassHealth Demonstration is currently under renewal for a possible three-year extension. It is set to expire June 30, 2008.

Description: The MassHealth section 1115(a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial MassHealth demonstration was approved in 1997 to enroll most Medicaid recipients into managed care organizations (Medicaid managed care program).

Unique features of the Demonstration include the Insurance Partnership (IP) Program and the Safety Net Care Pool. The IP program is an employer sponsored insurance (ESI) program, which provides a subsidy for employers with 50 or fewer employees as long as the employer contributes at least 50 percent of the total premium for the employee and any dependents. In addition to managed care savings, funds formerly used to make payment adjustments to disproportionate share hospitals (DSH) also are used to provide health care coverage.

On April 12, 2006, the State adopted legislation designed to provide access to affordable health insurance coverage to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006, titled An Act Providing Access to Affordable, Quality, Accountable Health Care (Act), builds upon the MassHealth section 1115 demonstration extension approved by CMS on January 26, 2005, which established the Safety Net Care Pool (SNCP). The Act accomplishes several goals of the negotiated demonstration extension including: improving the fiscal integrity of the MassHealth program, directing more federal and state health dollars to individuals and less to institutions, and subsidizing the purchase of private insurance for low-income individuals to reduce the number of uninsured in the Commonwealth. ■

Measurement and Assessment Activities Related to CMS Education and Outreach under the National Medicare & You Education Program

Project No: 500-00-0032/13
Project Officer: Suzanne Rotwein
Period: July 2005 to July 2008
Funding: $2,288,389
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Abt will continue to conduct formative research on health plan quality measures and complete the project's activities. The period of performance was extended to July 2008.

Description: This Task Order continues CMS's assessment of the education and outreach activities of the National Medicare & You Education Program (NMEP) to include the provisions of the Medicare Modernization Act (MMA) passed in 2003. The project involves monitoring systems that provide rapid feedback to management regarding operations, efficiency, and effectiveness of the NMEP. Ten case study site visits which include focus groups, interviews, participant observation, and telephone and mail surveys are utilized. Specifically, tasks involve talking to new and currently enrolled people with Medicare, CMS partners and employers. This rapid feedback will be used for continuous quality improvement. ■

Measures Support Work for a Medicare Hospital Payment Performance (P4P)

Project No: HHSM-500-2005-00020I/02
Project Officer: Mark Koepke
Period: September 2006 to September 2007
Funding: $938,522
Principal Investigator: Christopher Tompkins
Award: Task Order (MRAD)
Awardee: Brandeis University, Florence Heller Graduate School
P.o. Box 549110
Waltham, MA 02254-9110

Status: The project is complete.

Description: This task order will support CMS in assessing hospital performance measure issues for its Payment for Performance (P4) program. The SOW includes tasks such as developing criteria for the selection of hospital performance measures for P4P, applying the criteria to hospital measures currently used for pay for report (P4R) in order to evaluate them for transition to their use in P4P, identifying procedures for modifying and maintaining P4P measures, identifying gaps in hospital performance measurement that are particularly pertinent to P4P, and conducting analysis of relevant analytic questions. ■

Medi-Cal Hospital Uninsured Care

Project No: 11-W-00193/09
Project Officer: Steven Rubio
Period: August 2005 to August 2010
Funding: $0
Principal Investigator: Stan Rosenstein
Award: Waiver-Only Project

Awardee: California, Department of Health Services
1501 Capitol Avenue, Suite 71.6086, MS 4000, PO Box 942732
Sacramento, CA 94234-7320

Status: On October 5, 2007, CMS approved the State's August 28, 2006, amendment request to enable the State to develop and implement the Coverage Initiative. The amount of funding available for the Coverage Initiative is $180 million annually in SNCP funding for Demonstration Years 3 through 5.

Description: This demonstration restructures the financing of the State share of Medicaid expenditures for governmental hospitals, creates a Safety Net Care Pool ($766 million per year) to fund provider claims for care for the uninsured and continues the authority of the State to selectively contract with hospitals for negotiated rates. $180 million per year of the Safety Net Care Pool is available contingent on the State meeting milestones related to expansion of Medicaid managed care for ABD populations (Demonstration Years 1 and 2) and implementation of a Coverage Initiative for the uninsured (Demonstration Years 3 through 5). The State did not meet the requirements spelled out for Years 1 and 2.

The following are the guiding principles that were used to provide the framework for the Coverage Initiative (CI):

· Use of organized delivery systems to manage the care of the uninsured;

· Promotion of the use of preventive services and early intervention;

· Promotion of personal responsibility for service utilization;

· The CI is not an entitlement program for either the State, beneficiaries, or participating providers;

· Cover uninsured individuals who have no eligibility for Medi-Cal or Healthy Families; and

· Develop the CI in a manner to ensure long term viability within existing safety net health care systems.

The principle activity under this Demonstration is the reimbursement of providers for the uncompensated cost of care for the uninsured. ■

Medicaid Analytic Extract (MAX) Data Development: 2003-2007

Project No: 500-00-0047/06
Project Officer: David Baugh
Period: September 2005 to September 2008
Funding: $1,709,149
Principal Investigator: Suzanne Dodds
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has completed development of MAX data for 2003. Work is well under way on the MAX data for 2004. We anticipate that these data will be available to the user community by late 2007 or early 2008.

Description: The purpose of this task order is to have Medicaid eligibility and services claims experts to develop business "rules" to transform Medicaid (and SCHIP) person-level data records from the Medicaid Statistical Information System (MSIS) into records in the Medicaid Analytic eXtract (MAX) system. These business rules involve a number of activities related to eligibility, type of service and combination of MSIS claims to create MAX final action service records. This involves reviewing MSIS documentation, developing MSIS to MAX business "rules", possible interaction wtih State Medicaid agency personnel to gather information, clarify issues and/or devise corrective action strategies. The contractor passes the business "rules" to another party, known here as the MAX producer, who processes the MSIS files according to the MAX business rules to create the MAX data files. Once the MAX producer develops MAX data, this contractor performs a comprehensive assessment of data quality and validity to assure that the final MAX data are of the highest possible quality. The validation process may involve a number of iterations between the MAX producer and the contractor until data quality issues are resolved. Upon acceptance of the final MAX data files, the contractor assists the Federal project officer to prepare the data for access by the user community which includes CMS, other HHS components, other Federal and State agencies, foundations, consulting firms, and academic institutions. This includes preparation of explanatory materials on the business rules, data validation reports, data anomaly reports and limited technical consultation on data issues. Interested parties may obtain additional information at the CMS MAX web site: http://www.cms.hhs.gov/Medi

caidDataSourcesGenInfo/07_MAXGeneralInformation.asp#TopOfPage ■

Medicaid Infrastructure Grants - States A to M

Project No: 2008-MIG-AM
Project Officer: Effie Shockley
Joseph Razes
Period: October 2000 to December 2008
Funding: $101,735,190
Award: Grant
Awardee: See Status
The awardees are included in the status.

Status: Here is the status of all of the 2008 Medicare Infrastructure Grants sorted in alphabetical order from letter A through M:

State: Alabama (Y1)

Grant Number: 1QACMS030229

Awardee: Alabama Department of Rehabilitation Services

Funding: $500,000

Project Investigator: Steve Shivers

State: Alaska (Y4)

Grant Number: 11-P-92421-0/03

Awardee: Alaska Department of Health and Social Services

Funding: $2,050,000

Project Investigator: Millie Ryan

State: Arizona (Y2)

Grant Number: 1QACMS300122/01

Awardee: Arizona Health Care Cost Containment System

Funding: $1,000,000

Project Investigator: Debi Wells

State: Arkansas (Y1)

Grant Number: 1QACMS030230

Awardee: Arkansas Department of Human Services

Funding: $500,000

Project Investigator: Scott Holliday

State: California (Y4)

Grant Number: 11-P-92399-9/03

Awardee: Sonoma State University

Funding: $7,099,274

Project Investigator: Megan Juring

State: Connecticut (Y3)

Grant Number: 1QACMS30050/02

Awardee: Connecticut Department of Social Services

Funding: $1,2161,078

Project Investigator: Amy Porter

State: District of Columbia (Y2)

Grant Number: 1QACMS300125/01

Awardee: District of Columbia Department of Health

Funding: $1,000,000

Project Investigator: Robert Cosby

State: Florida (Y1)

Grant Number: 1QACMS030231

Awardee: Florida Agency for Persons with Disabilities

Funding: $650,000

Project Investigator: J.B. Black

State: Hawaii (Y2)

Grant Number: 1QACMS300120/01

Awardee: University of Hawaii

Funding: $1,000,000

Project Investigator: Georgette Sokumoto

State: Illinois (Y2)

Grant Number: 1QACMS300121/01

Awardee: Illinois Department of Healthcare and Family Services

Funding: $500,000

Project Investigator: Pat Curtis

State: Indiana (Y1)

Grant Number: 1QACMS030232

Awardee: Family and Social Services Administration

Funding: $750,000

Project Investigator: Natalie Angel

State: Iowa (Y1)

Grant Number: 1QACMS030233

Awardee: Department of Human Services

Funding: $722,500

Project Investigator: Jenifer Steenblock

State: Kansas (Y2)

Grant Number: 1QACMS300127/01

Awardee: Kansas Health Policy Authority

Funding: $1,686,160

Project Investigator: Mary Ellen Wright

State: Louisiana (Y3)

Grant Number: 1QACMS30052/02

Awardee: Louisiana State Department of Health & Hospitals

Funding: $1,500,000

Project Investigator: Elaine Richard

State: Maine (Y4)

Grant Number: 11-P-92409-1/03

Awardee: Maine Department of Health and Human Services

Funding: $2,525,000

Project Investigator: Muriel Littlefield

State: Maryland (Y2)

Grant Number: 1QACMS300119/01

Awardee: Maryland Department of Health and Mental Hygiene

Funding: $1,150,000

Project Investigator: Terri Fraser

State: Massachusetts (Y1)

Grant Number: 1QACMS030234

Awardee: University of Massachusetts Medical School

Funding: $3,778,321

Project Investigator: Patricia McNulty

State: Michigan (Y2)

Grant Number: 1QACMS300124/01

Awardee: Michigan Department of Community Health

Funding: $1,212,000

Project Investigator: Michael Head

State: Minnesota (Y4)

Grant Number: 11-P-92405-5/03

Awardee: Minnesota Department of Human Services

Funding: $9,440,107

Project Investigator: MaryAlice Mowry

State: Montanta (Y3, NCE)

Grant Number: 1QACMS300053/02

Awardee: Montanta Department of Public Health and Human Services

Funding: $1,000,000

Project Investigator: Gail Briese-Zimmer

Description: The Medicaid Infrastructure Grant Program is authorized under Section 203 of the Ticket-to-Work and Work Incentives Improvement Act. The 11-year competitive grant program provides funding to States for Medicaid infrastructure development that will build supports for people with disabilities who would like to be employed. States are encouraged to use grant funding to implement and develop the optional working disabled eligibility group (Medicaid buy-in), increase the availability of statewide personal assistance services, form linkages with other State and local agencies that provide employment related supports, and create a seamless infrastructure that will maximize the employment potential of all people with disabilities.

For additional information concerning the Medicaid Infrastructure Grant Program, please visit our Web site at www.cms.hhs.gov/twwiia. ■

Medicaid Infrastructure Grants - States N to W

Project No:	2008-MIG-NW
Project Officer:	Effie Shockley Joseph Razes
Period:	October 2000 to December 2008
Funding:	$101,735,190
Award:	Grant
Awardee:	See Status The awardees are included in the status.

Status: Here is the status of all of the 2008 Medicare Infrastructure Grants sorted in alphabetical order from letter N through W:

State: Nebraska (Y4)

Grant Number: 11-P-92404-7/03

Awardee: Nebraska Department of Health and Human Services System

Funding: $2,050,000

Project Investigator: Vivianne Chaumont

State: Nevada (Y4)

Grant Number: 11-P-92412-9/03

Awardee: Nevada Department of Health and Human Services

Funding: $2,050,000

Project Investigator: Constance Anderson

State: New Hampshire (Y2)

Grant Number: 1QACMS300123/01

Awardee: New Hampshire Department of Health and Human Services

Funding: $2,873,957

Project Investigator: Matthew Ertas

State: New Jersey (Y2)

Grant Number: 1QACMS300118/01

Awardee: New Jersey Department of Human Services

Funding: $1,000,000

Project Investigator: William Ditto

State: New Mexico (Y4)

Grant Number: 11-P-92398-6/03

Awardee: New Mexico Human Services Department

Funding: $3,581,493

Project Investigator: Ernesto Rodriguez

State: North Carolina (Y6, NCE)

Grant Number: 11-P-91780-4/05

Awardee: North Carolina Department of Health and Human Services

Funding: $2,349,339

Project Investigator: Wayne Howell

State: North Dakota (Y2)

Grant Number: 1QACMS300054/02

Awardee: Minot State University

Funding: $1,500,000

Project Investigator: Tom Alexander

State: Ohio (Y1)

Grant Number: 1QACMS030235

Awardee: Ohio Department of Job and Family Services

Funding: $500,000

Project Investigator: Charlene Alexander

State: Oregon (Y4)

Grant Number: 11-P-92415-0/03

Awardee: Oregon Department of Human Services

Funding: $2,248,563

Project Investigator: Sara Kendall

State: Pennsylvania (Y3, NCE)

Grant Number: 1QACMS300056/02

Awardee: Pennsylvania Department of Public Welfare

Funding: $1,000,000

Project Investigator: Trudy Johnson

State: Rhode Island (Y4)

Grant Number: 11-P-93060-1/03

Awardee: University of Rhode Island

Funding: $2,000,000

Project Investigator: Elaina Goldstein

State: South Dakota (Y3)

Grant Number: 1QACMS300057/02

Awardee: South Dakota Department of Human Services

Funding: $1,500,000

Project Investigator: Grady Kickul

State: Texas (Y1)

Grant Number: 1QACMS030236

Awardee: Texas Department of Assistive and Rehabilitative Services

Funding: $500,000

Project Investigator: Mr. Lynn Blackmore

State: Utah (Y4)

Grant Number: 11-P-92406-8/03

Awardee: Utah Department of Health

Funding: $2,100,000

Project Investigator: Carol Ruddell

State: Vermont (Y4)

Grant Number: 11-P-92403-1/03

Awardee: Vermont Agency of Human Services

Funding: $2,230,000

Project Investigator: Susan Wells

State: Virginia (Y1)

Grant Number: 1QACMS030237

Awardee: Virginia Department of Medical Assistance Services

Funding: $500,000

Project Investigator: Jack Quigley

State: Washington (Y4)

Grant Number: 11-P-92411-0/03

Awardee: Washington Department of Social and Health Services

Funding: $2,100,000

Project Investigator: Stephen Kozak

State: West Virginia (Y3)

Grant Number: 1QACMS300059/02

Awardee: West Virginia Division of Rehabilitation Services

Funding: $1,500,000

Project Investigator: Deborah Lovely

State: Wisconsin (Y4)

Grant Number: 11-P-92410-5/03

Awardee: Wisconsin Department of Health and Family Services

Funding: $18,927,398

Project Investigator: John Reiser

State: Wyoming (Y2)

Grant Number: 1QACMS300126/01

Awardee: University of Wyoming

Funding: $1,000,000

Project Investigator: Dave Schaad

Description: The Medicaid Infrastructure Grant Program is authorized under Section 203 of the Ticket-to-Work and Work Incentives Improvement Act. The 11-year competitive grant program provides funding to States for Medicaid infrastructure development that will build supports for people with disabilities who would like to be employed. States are encouraged to use grant funding to implement and develop the optional working disabled eligibility group (Medicaid buy-in), increase the availability of statewide personal assistance services, form linkages with other State and local agencies that provide employment related supports, and create a seamless infrastructure that will maximize the employment potential of all people with disabilities.

For additional information concerning the Medicaid Infrastructure Grant Program, please visit our Web site at www.cms.hhs.gov/twwiia. ■

Medicaid Statistical Information System (MSIS) Expansion and Data Quality Support

Project No: 500-00-0047/04
Project Officer: Denise Franz
Period: September 2003 to September 2008
Funding: $4,331,461
Principal Investigator: Suzanne Dodds
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research (Cambridge)
50 Church Street
Cambridge, MA 02138-3726

Status: Mathematica continues to peform technical support for the quality of State-submitted MSIS data by performing validation reviews of these data using programs developed under previous tasks and refined in recent tasks. They continue to work with States to improve the ongoing quality of their data submissions, addressing coding issues associated with encounter data, as well as fee-for-service data, and facilitating revised coding which may result from recently implemented Health Insurance Portability and Accountability Act implementation.

The subject matter work on this project is ongoing We are currently in option year four of this contract. The contractor's technical proposal, dated June 29, 2007, is hereby incorporated by reference and made a part of this Task Order.

Description: The contractor will provide technical support to States during the Medicaid Statistical

Information System (MSIS) implementation period to proactively encourage good State understanding of the MSIS. The contractor will use validation tools developed under a previous contract to analyze the quality of the data after it is received at CMS. The contractor will also support the analysis of Medicaid Data and work directly with States to isolate root causes of quality problems and identify possible solutions. The contractor will also work with the States to support State application and implementation efforts. ■

Medical Adult Day-Care Services Demonstration

Project No: ORDI-05-0005
Project Officer: Armen Thoumaian
Bertha Williams
Period: January 2006 to January 2009
Funding: $431,400
Principal Investigator: Henry Goldberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Proposals from potential applicants were solicited through a notice published in the Federal Register on June 24, 2005 with applications due on September 24, 2005. Final site selection was completed May 2006. Implementation of the demonstration began August 1, 2006. The five sites are:

Aurora Visiting Nurses Association, Milwaukee, Wisconsin; Doctor's Care Home Health, McAllen, Texas; Landmark Home Health Care Services, Allison Park, Pennsylvania; Metropolitan Jewish Health System, Brooklyn, New York; and Neighborly Care Network, St. Petersburg, Florida.

Abt Associates, as the support contractor, will continue to assist CMS in the management and monitoring of the demonstration sites through July 2009.

Description: Section 703 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) directs the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. The demonstration was limited to five sites in states that license or certify medical adult day care facilities. Under the demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

The demonstration will run for a period of 3 years and will be conducted through no more than 5 home health agency sites in States selected by CMS. Up to 15,000 beneficiaries may participate in the demonstration at any one time.

Abt Associates was competitively awarded The Home Health Support Contract to provide assistance to CMS in the implementation and management of the Medical Adult Day Care Services Demonstration. ■

Medicare Acute Care Episode Demonstration: Design, Implementation, and Management

Project No: HHSM-500-2005-00029I/10
Project Officer: Armen Thoumaian
Period: September 2007 to September 2012
Funding: $200,000
Principal Investigator: Nancy McCall
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Additional funding for this contract is pending. Demonstration implementation is expected in FY 2009.

Description: This Task Order will provide assistance to CMS in the development, site solicitation, implementation, and management of the Acute Care Episode Demonstration (ACED). The assistance will include background detail and Part A and Part B pricing information for a set of bundled surgical episode packages and post acute care rehabilitation packages. ■

Medicare Contractor Provider Satisfaction Survey (MCPSS)

Project No: 500-01-0020/04
Project Officer: Gladys Valentin
Period: September 2004 to September 2009
Funding: $4,817,250
Principal Investigator: Vasudha Narayanan
Award: Task Order (ADDSTO)
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: The project is in the fourth year of a five-year contract. The contract was modified to provide incremental funding.

Description: The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of Medicare Fee-for-Service (FFS) contractors. Specifically, the survey will enable the Centers for Medicare & Medicaid Services (CMS) to begin using provider satisfaction as an additional measure to evaluate performance of key services performed by Medicare contractors and support process improvement efforts by contractors to enhance service. CMS will use the results for Medicare contractor oversight. ■

Medicare Current Beneficiary Survey

Project No: 500-2004-00006C
Project Officer: Franklin Eppig
Period: February 2004 to February 2009
Funding: $60,852,747
Principal Investigator: Richard Apodaca
Award: Contract
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: The MCBS has been in the field continuously since Fall 1991. It is currently in its 49th round of interviewing. To date, public use data files are available for 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004 and 2005.

Description: The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid CMS's administration, monitoring, and evaluation of the Medicare Program. The survey is focused on health care use, cost, and sources of payment. Data from the MCBS will enable CMS to:

• Determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services.

• Develop reliable and current information on the use and cost of services not covered by Medicare (e.g., long-term care).

• Ascertain all types of health-insurance coverage and relate coverage to sources of payment.

• Monitor the financial effects of changes in the Medicare Program.

Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Chestnut Hill Site

Project No: 95-W-00150/01
Project Officer: Armen Thoumaian
Period: June 2001 to February 2007
Funding: $0
Principal Investigator: Aggie Casey
Award: Waiver-Only Project
Awardee: Mind/Body Medical Institute
824 Boylston Street
Chestnut Hill, MA 02467

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites

receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Nashville Site

Project No: 95-W-00176/04
Project Officer: Armen Thoumaian
Period: December 2001 to February 2007
Funding: $0
Principal Investigator: Diane Drennan
Award: Waiver-Only Project
Awardee: Baptist Hospital System, Cardiac Wellness Program
2000 Church St
Nashville, TN 37236

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Richmond Site

Project No: 95-W-00179/03
Project Officer: Armen Thoumaian
Period: October 2002 to February 2007
Funding: $0
Principal Investigator: Sherri Strickler
Award: Waiver-Only Project
Awardee: Bon Secours Richmond Health System
5801 Bremo Road
Richmond, VA 23226

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - South Bend Site

Project No: 95-W-00178/05
Project Officer: Armen Thoumaian
Period: August 2001 to February 2007
Funding: $0
Principal Investigator: Colleen Milling
Award: Waiver-Only Project

Awardee: St. Joseph Regional Medical Center
801 E. LaSalle Ave
South Bend, IN 46617

Status: The site ended participation in January 2006. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Tacoma Site

Project No: 95-W-00149/10
Project Officer: Armen Thoumaian
Period: March 2003 to February 2007
Funding: $0
Principal Investigator: Dr. Mary Dean
Award: Waiver-Only Project
Awardee: MultiCare Health System
1901 South Union Avenue, Suite A227
Tacoma, WA 98405

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Warwick Site

Project No: 95-W-00146/01
Project Officer: Armen Thoumaian
Period: September 2001 to February 2007
Funding: $0
Principal Investigator: Barbara Haydon
Award: Waiver-Only Project
Awardee: Care New England Wellness Center
2191 Post Rd
Warwick, RI 02886

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Cardiac Wellness Extended Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Charleston Site

Project No: 95-W-00137/03
Project Officer: Armen Thoumaian
Period: May 2002 to February 2007
Funding: $0
Principal Investigator: Ed Haver
Award: Waiver-Only Project
Awardee: Charleston Area Medical Center
3200 MacCorkle Avenue, SE
Charleston, WV 25304

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to provide one of two nationally known treatment models: The Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Clarksburg Site

Project No: 95-W-00139/03
Project Officer: Armen Thoumaian
Period: March 2002 to February 2007
Funding: $0
Principal Investigator: Toni Marascio
Award: Waiver-Only Project
Awardee: United Hospital Center
Plaza #3 Hospital Plaza
Clarksburg, WV 26301

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Erie Site

Project No: 95-W-00151/03
Project Officer: Armen Thoumaian
Period: August 2003 to February 2007
Funding: $0
Principal Investigator: Walter Horner
Award: Waiver-Only Project
Awardee: Hamot Medical Center
3330 Peach Street, Suite 211
Erie, PA 16508

Status: Site participation in the demonstration ended February 28, 2007. The evaluation contractor will continue to collect relevant data through February 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the

Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Greensburg Site

Project No: 95-W-00181/03
Project Officer: Armen Thoumaian
Period: July 2003 to February 2007
Funding: $0
Principal Investigator: Nancy Urick
Award: Waiver-Only Project
Awardee: Westmoreland Regional Hospital
532 Pittsburgh Street
Greensburg, PA 15601

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Huntington Site

Project No: 95-W-00140/03
Project Officer: Armen Thoumaian
Period: November 2002 to February 2007
Funding: $0
Principal Investigator: Mona Wilson
Award: Waiver-Only Project
Awardee: St. Mary's Medical Center
2900 1st Avenue
Huntington, WV 25702

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Monongahela Site

Project No: 95-W-00133/03
Project Officer: Armen Thoumaian
Period: May 2003 to February 2007
Funding: $0
Principal Investigator: Randall Komacko, MPT
Award: Waiver-Only Project
Awardee: Monongahela Valley Hospital
1163 Country Club Road
Monongahela, PA 15063

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Morgantown Site

Project No: 95-W-00144/03
Project Officer: Armen Thoumaian
Period: May 2002 to February 2007
Funding: $0
Principal Investigator: David Harshbarger
Award: Waiver-Only Project
Awardee: West Virginia University Hospital
Medical Center Drive
Morgantown, WV 26506-8120

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - New Castle Site

Project No: 95-W-00142/03
Project Officer: Armen Thoumaian
Period: June 2003 to February 2007
Funding: $0
Principal Investigator: Joyan L. Urda
Award: Waiver-Only Project
Awardee: Jameson Health System
1211 Wilmington Avenue, Room 430
New Castle, PA 16105

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Pittsburgh

Project No: 95-W-00131/03
Project Officer: Armen Thoumaian
Period: August 2003 to February 2007
Funding: $0
Principal Investigator: David Seigneur
Award: Waiver-Only Project
Awardee: Allegheny General Hospital
320 North Avenue
Pittsburgh, PA 15212

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Trexeltown Site

Project No: 95-W-00180/03
Project Officer: Armen Thoumaian
Period: March 2004 to February 2007
Funding: $0
Principal Investigator: Kim Sterk
Award: Waiver-Only Project
Awardee: Lehigh Valley Hospital
6900 Hamilton Blvd.
Trexeltown, PA 18087

Status: Site participation and treatment under the demonstration ended February 28, 2007. The evaluation contractor will continue to collect relevant data through February 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Wheeling Site

Project No: 95-W-00135/03
Project Officer: Armen Thoumaian
Period: June 2002 to February 2007
Funding: $0
Principal Investigator: Joe Slavic
Award: Waiver-Only Project
Awardee: Howard Long Wellness Center At Wheeling Hospital
800 Medical Park
Wheeling, WV 26003

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll

up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Windber Site

Project No: 95-W-00134/03
Project Officer: Armen Thoumaian
Period: October 2002 to February 2007
Funding: $0
Principal Investigator: Patty Feltman
Award: Waiver-Only Project
Awardee: Windber Medical Center
600 Somerset Avenue
Windber, PA 15963

Status: Site participation ended February 28, 2007. The evaluation contractor continues to collect data through February 28, 2008.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. ■

Medicare Lifestyle Modification Program Demonstration Evaluation

Project No: 500-95-0060/02
Project Officer: Armen Thoumaian
Period: September 2000 to September 2008
Funding: $4,197,730
Principal Investigator: Donald Shepard
William B. Stason
Award: Task Order
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: In September 2001, the evaluation was expanded to include a longer follow-up period of treatment and control patients, and to include a critical review of literature of all lifestyle modification programs worldwide. In September 2003, following the implementation of new enrollment criteria, the contract was expanded to include another matched control group of beneficiaries that have had cardiac rehabilitation as part of traditional treatment. In addition, the evaluation was expanded to include a study of the Medicare cardiac rehabilitation benefit.

Description: This project evaluates the health outcomes and cost effectiveness of the Medicare Lifestyle Modification Program Demonstration for Medicare beneficiaries with coronary artery disease (CAD). The demonstration tests the feasibility and cost effectiveness of providing payment for cardiovascular lifestyle modification program services to Medicare beneficiaries. The goal of the evaluation is to provide an assessment of the health benefit and cost-effectiveness of treatment for Medicare beneficiaries with CAD who enroll in the 12-month long cardiovascular lifestyle modification programs at the demonstration sites. The evaluation of the demonstration assesses the overall performance of the demonstration sites, including the quality of health care delivery over the course of the demonstration period. The evaluation also assesses the use of systems for administration, claims processing and payment, and the routine monitoring of quality of care. The evaluation consists, in part, of a pre/post quasi-experimental, matched pairs design with a 1-year follow-up of a maximum of 3,600 treatment enrollees and 3,600 comparison group subjects. Data collection included diagnostic and clinical outcome information from treatment and control patient physicians and the treatment program, supplemented by medical record review, patient surveys, program case studies, and Medicare claims data.

Allowances were made to provide an incentive payment to the patients' physician for information reporting. ■

Medicare Lifestyle Modification Program Demonstration: Quality Monitoring and Review

Project No: 500-02-0012
Project Officer: Kathleen Connors de laguna
Period: July 1999 to July 2008
Funding: $1,886,912
Principal Investigator: Roxanne Rodgers
Award: Task Order (ADP Support)
Awardee: Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, MD 21601-7098

Status: The demonstration was implemented October 1, 1999. On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act (2001), the Cardiac Wellness Lifestyle Program of the Mind/Body Medical Institute (M/BMI) was incorporated into the overall demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. On May 3, 2002, enrollment criteria were again amended to include patients with moderate cardiovascular disease and the demonstration enrollment period was extended to February 28, 2005 with treatment under the demonstration ending in 2006. In February 2005, the demonstration was extended another year with treatment ending February 28, 2007. At the end of the treatment period there were 13 sites offering the Dr. Dean Ornish Program and 6 sites offering the Cardiac Wellness Expanded Program. Collection of quality monitoring data will continue until February 28, 2008 and provided to the demonstration evaluator.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to provide one of two nationally known treatment models: The Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage, and the Preventive Medicine Research Institute, or The Cardiac Wellness Expanded Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. Sites offering either model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. This project provides continuous quality monitoring of the demonstration sites to assure the health and safety of participating Medicare patients. ■

Medicare Part D Program Evaluation

Project No: HHSM-500-2005-00029I/09
Project Officer: Aman Bhandari
Period: September 2007 to September 2009
Funding: $658,191
Principal Investigator: Mel Ingber
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The research is ongoing.

Description: The purpose of this evaluation is to examine the impact of the Part D benefit on the broader Medicare Program as well as its impact on sub-populations of beneficiaries. To accomplish its purpose, the study is divided into three separate components. The first component is an analysis of the impact of the Part D benefit on the traditional Medicare program and is included in the base award. The other two components - an analysis of the impact of the Part D benefit on the Medicare Advantage program and an anlysis of the impact of the Medicare Part D benefit on beneficiaries with chronic conditions - are included as two separate, optional tasks. The Contractor will be responsible for designing and conducting an evaluation to assess these impacts. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order - Mathematica Policy Research

Project No: HHSM-500-2005-00025I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: This contract is an umbrella contract. There are currently five (5) task orders awarded under the contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order - URREA

Project No: HHSM-500-2005-000311
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Arbor Research Collaborative for Health formerly known as URREA (University Renal Research and Education Association)
315 West Huron, Suite 260
Ann Arbor, MI 48103

Status: This is an umbrella contract. There is currently one (1) task order awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), in addition to other CMS program reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - JEN Associates, Inc.

Project No: HHSM-500-2005-00023I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: JEN Associates, Inc.
P.O. Box 39020
Cambridge, MA 02139

Status: This is an umbrella contract. There are no active task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Lewing

Project No: HHSM-500-2005-00024I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: This is an umbrella contract. Currently there are no active task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - MEDSTAT

Project No: HHSM-500-2005-00026I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: This is an umbrella contract. Currently, there are no active task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilties. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Rand Corporation

Project No: HHSM-500-2005-00028I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: This is an umbrella contract. Currently there are two (2) task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Research Triangle Institute

Project No: HHSM-500-2005-00029I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This is an umbrella contract. Currently there are eleven (11) task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - University of Minnesota

Project No: HHSM-500-2005-00027I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: This is an umbrella contract. Currently there are two (2) task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - University of Wisconsin

Project No: HHSM-500-2005-00032I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: University of Wisconsin - Madison
750 University Avenue
Madison, WI 53706

Status: This is an umbrella contract. Currently there are no active task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Urban Institute

Project No: HHSM-500-2005-00030I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Status: This is an umbrella contract. Currently there are no active task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - Abt

Project No: HHSM-500-2005-00018I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Task Order Contract, Base
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: This is an umbrella contract. Currently there are four (4) task order awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - American Institute for Research (AIR)

Project No: HHSM-500-2005-00019I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: American Institute for Research
3333 K Street, NW
Washington, DC 20007-3541

Status: This is an umbrella contract. Currently there is one task order awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - Brandeis University

Project No: HHSM-500-2005-00020I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: This is an umbrella contract. Currently there are three (3) task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - CNA

Project No: HHSM-500-2005-000211
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: C.N.A. Corporation
4825 Mark Center Drive
Alexandria, VA 22311-1850

Status: This is an umbrella contract. Currently there are no active task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - University of Colorado, CHPR

Project No: HHSM-500-2005-00022I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $1,000
Award: Master Contract, Base
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: This is an umbrella award. Currently there is one (1) task order awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstartion, evaluationa and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

MEDS-AD

Project No: 11-W-00205/04
Project Officer: Mark Pahl
Period: December 2005 to December 2010
Funding: $0
Principal Investigator: Thomas Arnold
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive
Tallahasee, FL 32308

Status: The Florida MEDS-AD demonstration was implemented January 1, 2006, and will run through December 31, 2010.

Description: The Florida MEDS-AD demonstration provides coverage for certain aged and disabled individuals with incomes up to 88 percent FPL. This optional Medicaid eligibility group was eliminated from the State plan in 2005. Enrollees receive services through the same delivery systems as the traditional Florida Medicaid program. The objective of the demonstration

is to evaluate the impact of providing high intensity pharmacy case management for individuals with a large volume of routine medications. The demonstration will be funded through savings generated from avoiding high cost institutional placement that would occur in the absence of pharmacy and medical services. ■

Mercy Medical Skilled Nursing Home Payment Demonstration

Project No: 95-W-00083/04
Project Officer: Juliana Tiongson
Period: January 2002 to December 2008
Funding: $0
Principal Investigator: Kathryn Parks
Award: Waiver-Only Project
Awardee: Mercy Medical
101 Villa Drive, P.O. Box 1090
Daphne, AL 36526-1090

Status: The project has been extended and will end in December 2008.

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.

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 ■

Minimum Data Set Technical Support Contract

Project No: 500-00-0032/15
Project Officer: Edwin Huff
Period: September 2005 to September 2008
Funding: $4,554,875
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The period of performance has been extended to September 2008. Optional Phase 3 has been deleted but the Statement of Work has been scaled down because requirements have changed. The contract title has changed to "MDS Technical Support Contract."

Description: The Minimum Data Set Technical Support Contract, formerly known as The Data Assessment and Verification Contractor (DAVE 2), supports the Center for Medicare & Medicaid Services (CMS) efforts in providing an ongoing centralized data surveillance process to assess the accuracy and reliability of the data particular to the health care provided by nursing facilities for these services. The findings will produce evidence for further actions at national, regional and State levels in addressing concerns in the areas of program integrity, beneficiary health and safety, and quality improvement. ■

Minnesota Prepaid Medical Assistance Project Assistance Plus (PMAP+)

Project No: 11-W-00039/05
Project Officer: Wanda Pigatt-canty
Period: April 1995 to June 2008
Funding: $0
Principal Investigator: Christine Bronson
Award: Demonstration
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: On September 4, 2007, the State submitted a request to amend various sections of the Attachment C of the Special Terms and Conditions (STC) to reduce premiums, the eliminate dental co-payments for adults, add outpatient mental health services for adults and change the payment methodology for medical education. The amendment is pending review.

Description: Prepaid Medical Assistance Project Plus (PMAP+) provides a managed care delivery system to Medicaid eligibles in Minnesota. PMAP is currently enrolling recipients in eighty-three of Minnesota's eighty-seven counties. The PMAP demonstration also provides title XIX matching funds for expansion coverage groups enrolled in MinnesotaCare. The demonstration eligibility expansion includes uninsured pregnant women, infant and children with an income of up to 275 percent of the FPL and parents/caretaker relatives with income up to 275 percent of the FPL or $50,000 and with assets up to $20,000. MinnesotaCare pregnant women, infants and children receive the full Medicaid benefits; parents and caretaker relatives receive a reduced Medicaid benefit. All of the beneficiaries that are enrolled in Minnesota Care are required to pay premiums on a sliding scale based upon income. In addition, co-payments are required for certain services. ■

Minnesota Senior Health Options/Minnesota Disability Health Options

Project No: 11-W-00024/05
Project Officer: Susan Radke
Period: April 1995 to December 2007
Funding: $0
Principal Investigator: Pamela Parker
Award: Waiver-Only Project
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: This dually eligible demonstration is approved for the period of January 1, 2005 through December 31, 2007. The State contracts with nine health care plans to provide MSHO services. MnDHO was approved to expand the MnDHO eligibility to beneficiaries diagnosed with Mental Retardation and Developmental Disabilities (MR/DD). Further, all nine health plans are currently approved Medicare Advantage Special Needs Plans (MA/SNPs). MSHO/MnDHO is transitioning from demonstration status to become full MA/SNPs by January 1, 2008. A new Medicare waiver demonstration that will apply a phase out of the frailty adjustment made to payments to the MA SNP health plans in the State of Minnesota will continue from January 1, 2008 through December 31, 2010.

Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute-care services for elderly dually eligible beneficiaries. Initially, under this demonstration, the State was being treated as a health plan that contracted with CMS to provide services, and provided those services through subcontracts with three health care plans. CMS approved the State's request in year 2001 to extend MSHO and expand eligibility criteria to include persons under the age of 65 with disabilities. The expansion program, titled "Minnesota Disability Health Options Program"(MnDHO), includes both disabled dually eligible beneficiaries and Medicaid eligible only beneficiaries. Administration of this program is similar to MSHO. Medicare services for MSHO and MnDHO are provided using a demonstration waiver under §402 of the Social Security Amendments of 1967. Medicaid services are provided under §1915(a) and §1915(c) of the Social Security Act. MSHO and MnDHO are managed care products that integrate Medicare and Medicaid financing; acute and long-term care service delivery, including home and community based waiver services for dually eligible and Medicaid eligible physically disabled adults and elderly in the State of Minnesota. MnDHO was implemented initially in Hennepin, Ramsey, Dakota, and Anoka counties and will expand to three more of the 10 MSHO counties. Enrollment in MSHO and MnDHO is voluntary and available to dually eligible beneficiaries living in institutions, community enrollees who meet institutional placement criteria, and other community enrollees whose needs do not meet institutional levels of care. ■

Missouri Managed Care Plus (MC+)

Project No: 11-W-00122/07
Project Officer: Juliana Sharp
Period: April 1998 to October 2007
Funding: $0
Principal Investigator: Pamela Parker
Award: Waiver-Only Project
Awardee: Missouri, Department of Social Services, Division of Medical Assistance
P.O. Box 6500
Jefferson City, MO 65102-6500

Status: The demonstration expired on October 15, 2007. The populations that were served under the demonstration at the time of expiration included optional targeted low-income children (up to 300 percent of the FPL) and postpartum uninsured women who lose their Medicaid eligibility 60 days after the birth of their child. The optional targeted low-income children transitioned into a combination State Children's Health Insurance

Program (SCHIP) program. The postpartum uninsured women transitioned into a separate, stand-alone section 1115 family planning demonstration, entitled Women's Health Services Program.

Description: The demonstration was a statewide program that provided Medicaid Managed Care to adults and children in the State that were not otherwise eligible for Medicaid. The demonstration ran concurrently with the State's current Section 1915(b) waiver, also known as Managed Care Plus (MC+). The demonstration also provided family planning services to postpartum uninsured women who lost their Medicaid eligibility 60 days after the birth of their child. ■

Monitoring Chronic Disease Care and Outcomes Among Elderly Medicare Beneficiaries with Multiple Chronic Diseases

Project No: HHSM-500-2005-00027I/01
Project Officer: Karyn Anderson
Period: September 2005 to September 2008
Funding: $381,722
Principal Investigator: A. Marshall McBean
Award: Task Order (MRAD)
Awardee: University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Mail Code Number 99
420 Delaware Street SE, D 355 Mayo Building
Minneapolis, MN 55455

Status: The project is in progress. Activity 1 has been submitted, corrections have been requested, and a final draft will be received back by Feb 29, 2008. Activity 2 is well underway. Activity 3 will require the use of Part D data and will therefore be delayed until such data has been made accessible to contractors.

Description: The purpose of this contract is to conduct analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. The 723 database will serve as the data source for the analytic studies to be conducted under this contract. ■

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

Status: Congress has extended the demonstration several times. 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. After the last extension, the demonstration did not accept new participants and was restricted to those who were in the program as of 1997.

More recently, there were 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 7,000 participants in the most recent year. The number of claims had 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.

The project ended at the end of calendar year 2006.

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. ■

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

Status: Congress has extended the demonstration several times. 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. After the last extension, the demonstration did not accept new participants and was restricted to those who were in the program as of 1997.

More recently, there were 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 7,000 participants in the most recent year. The number of claims had 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.

The project ended at the end of calendar year 2006.

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. ■

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

Status: Congress has extended the demonstration several times. 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. After the last extension, the demonstration did not accept new participants and was restricted to those who were in the program as of 1997.

More recently, there were 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 7,000 participants in the most recent year. The number of claims had 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.

The project ended at the end of calendar year 2006.

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. ■

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: Eva Lee
Award: Service Agreement
Awardee: City of San Jose
151 West Mission Street
San Jose, CA 95110

Status: Congress has extended the demonstration several times. 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. After the last extension, the demonstration did not accept new participants and was restricted to those who were in the program as of 1997.

More recently, there were 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 7,000 participants in the most recent year. The number of claims had 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.

The project ended at the end of calendar year 2006.

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. ■

Mystery Shopping

Project No: 500-00-0037/09
Project Officer: Barbara Cohen
Period: August 2005 to December 2007
Funding: $611,222
Principal Investigator: Lauren Blatt
Award: Contract
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

Status: Mystery Shopping for 1-800-MEDICARE ended in February 2006. Mystery Shopping for the SHIP program is continuing and the project will be extended with a no-cost extension to December 31, 2007.

Description: As part of the National Medicare Education Program (NMEP), the Centers for Medicare and Medicaid Services (CMS) must provide information about Medicare to beneficiaries, caregivers, providers, and partners. Performance assessment plays a critical part of the agency's efforts to provide this information. The Contractor shall provide assistance to CMS in assessing how well we are communicating with our

Medicare beneficiaries, caregivers, and providers. With the activity of mystery shopping, emphasis is directed to ability to communicate well with people with Medicare and with caregivers. This Task Order concerns mystery shopping assessments of two NMEP channels: 1-800-MEDICARE and the State Health Insurance Assistance Programs (SHIPSs). ■

National Evaluation of the Demonstration to Improve the Direct Service Community Workforce

Project No: 500-00-0048/01
Project Officer: Kathryn King
Period: September 2005 to September 2008
Funding: $973,989
Principal Investigator: John Engberg
Award: Task Order (RADSTO)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The contractor distributed the three surveys and compiled information from returned surveys. Site visits to all 10 grantees are complete and information has been analyzed. The draft outline of final report has been approved. A Revised Statement of Work entitled, "Funds for Evaluating the Oklahoma DSW Demonstration Site" and the Contractor's Technical Proposal dated August 8, 2007, were made a part of this task order.

Description: The purpose of this Task Order is to evaluate the impact of the 10 grants awarded by the Centers for Medicare and Medicaid Services (CMS) under the "Demonstration to Improve the Direct Service Community Workforce." These grants were awarded to test the effectiveness of the various interventions to improve the recruitment and retention of direct service workers. ■

National Implemention of Medicare CAHPS - MMC Survey

Project No: 500-01-0020/02
Project Officer: Amy Heller
Period: August 2003 to March 2007
Funding: $13,998,670
Principal Investigator: W. Sherman Edwards
Award: Task Order (ADDSTO)
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: This data collection effort ended March 30, 2007 however the MAHPS MA and FFS surveys continue under a different contracting mechanism.

Description: The Centers for Medicare & Medicaid Services (CMS) is an active participant in the CAHPS (Consumer Assessment of Health Plans) effort which is a cooperative agreement headed by the Agency for Health Care Research and Quality to develop standardized instruments and reporting formats for providing comparative information to aid consumers in making more informed health plan choices. The core CAHPS survey instrument developed for the adult commercial population is currently used to assess the care provided by health plans covering over 123 million Americans. In 1997, CMS sponsored the development of a Medicare version of the CAHPS survey for enrollees (hereinafter referred to as the Medicare Managed Care CAHPS Survey (MMC-CAHPS)). CMS has just completed the seventh annual nationwide administration of MMC-CAHPS. CMS has funded three different Medicare versions of the CAHPS surveys to assess beneficiaries' experiences and ratings of care within the Medicare Program—Medicare+Choice (M+C) Assessment Survey, M+C Disenrollee Survey, and the Fee-for-Service (FFS) Survey.

Medicare CAHPS Disenrollment Survey: There are two different disenrollment surveys. In the Fall of 2000, CMS began to conduct a separate annual survey of beneficiaries who voluntarily disenrolled from M+C organizations to gather information about their experiences with the plan they left. This survey is known as the Medicare CAHPS Disenrollment Assessment Survey. Results from the Disenrollment Assessment Survey are combined with those from the Enrollee Survey for reporting to the public and to plans. Reporting the information in this way provides a more accurate account of all Medicare beneficiaries' experiences with M+C organizations. CMS added the survey results from disenrollees to the overall survey results to ensure that positive survey results were not

the result of CMS's continuous enrollment policy. References to the MMC-CAHPS survey refer to the combination of the MMC-CAHPS Enrollee Survey and the Disenrollment Assessment Survey.

CMS also sponsors the Medicare CAHPS Disenrollment Reasons Survey. The purpose of the Reasons Survey is to collect data about the reasons why Medicare beneficiaries leave their M+C health plans. Although data from the Reasons Survey are analyzed on an annual basis, sampling and data collection are conducted on a quarterly basis. The Reasons Survey has been conducted for CMS each year since 2000 and survey results can be found on Medicare's website, www.Medicare.gov, through Medicare Health Plan Compare and Medicare Personal Plan Finder.

FFS CAHPS: CMS also developed a Medicare version of the CAHPS survey for beneficiaries enrolled in Original Medicare (FFS-CAHPS). CMS began implementation of this survey in Fall 2000 and has just completed the third annual nationwide administration. The results of both surveys are case-mix adjusted to account for differences in the FFS and managed care populations and reported together through the Handbook and on Medicare's website, www.Medicare.gov, through Medicare Health Plan Compare and Medicare Personal Plan Finder. ■

New Jersey Cash and Counseling Demonstration

Project No: 11-W-00118/02
Project Officer: Marguerite Schervish
Period: May 2000 to April 2008
Funding: $0
Principal Investigator: William Ditto
Award: Waiver-Only Project
Awardee: New Jersey, Department of Human Services
222 South Warren St, PO Box 700
Trenton, NJ 08625-0700

Status: New Jersey received approval on to eliminate the randomization component of the demonstration design. All demonstration enrollees, including those once randomized into the control group, will have the ability to self-direct the provision of their personal care services. CMS granted New Jersey a three-year extension of demonstration authority, which is now in effect until April 30, 2008.

Description: The purpose of these demonstrations is to provide greater autonomy to consumers of long-term care services by empowering them to purchase the assistance they require to perform activities of daily living. They are section 1115 waiver projects awarded to the States of Arkansas, Florida, and New Jersey. Persons chosen to participate in this demonstration will be assigned to either a treatment or a control group. Beneficiaries selected for the treatment group will receive cash allowances, which they can use to select and purchase the personal assistance services (PAS) that meet their needs. Fiscal intermediary and counseling services will be available to those members of the treatment group who wish to utilize them. Individuals assigned to the control group will receive PAS services from traditional Medicaid providers, with the State making all vendor payments. Other partners in this collaborative effort include the Robert Wood Johnson Foundation, which funded the development of these projects; the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, which is funding the evaluation; the National Program Office at the University of Maryland's Center on Aging, which is performing various coordinating functions; and the National Council on Aging, which has served in an advisory capacity. An evaluation contract has been awarded to Mathematica Policy Research, Inc. It will assess differential outcomes with respect to cost, quality, and client satisfaction between traditional PAS services and alternative choice modalities. ■

New Mexico Health Care Reform Demonstration

Project No: 11-W-0012416
Project Officer: Andrea Casart
Period: January 2005 to December 2007
Funding: $0
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The continuation period ended on December 31, 2007.

Description: On September 14, 1998, New Mexico submitted a proposal for the New Mexico Section 1115 Demonstration Project, a 5-year section 1115 demonstration. On January 11, 1999, the State was permitted to implement its title XXI Medicaid expansion to cover children in families through age 18 with income from 185 percent up to 235 percent of the Federal

Poverty Level (FPL). New Mexico operates its Title XXI State Children's Health Insurance Program (SCHIP) Medicaid expansion through this demonstration. This demonstration permits New Mexico to have co-payment requirements and a 6-month waiting period for the demonstration population. The State requested a 3-year extension of project number 11-W-0012416 entitled "The New Mexico Section 1115 Demonstration Project." The renewal was approved on June 14, 2004. This extension is authorized under 1115(e) of the Social Security Act. ■

Northern New England Vascular Surgery Quality Improvement Initiative

Project No: 18-C-91674/01-02
Project Officer: Lindsey Bramwell
Period: September 2001 to September 2008
Funding: $650,000
Principal Investigator: Jack Cronenwett
Award: Grant
Awardee: Dartmouth University
HB 7850, 500 East Borwell,
Research Building Dartmouth,
Hitchcock Medical Center
Hanover, NH 03756

Status: A cooperative clinical data registry was developed among the nine major hospitals in NNE that perform 80 percent of all vascular surgery in the region. Data including indications, comorbidities, operative details, and outcomes will be collected for carotid endarterectomy, abdominal aortic aneurysm repair, and lower extremity bypass surgery. The developed shared data registry prospectively collects data on vascular procedures. Data includes indications, comorbidities, selected procedural details, and short-term outcomes and analyzes patterns of care and outcomes of hospitals and surgeons. The variations in procedure rates and risk-adjusted outcomes will be added to account for the differences in case mix to improve outcomes and reduce geographic variation in procedure rates by using benchmarking and visits by clinical teams from each center for comparative process analysis and continuous quality improvement.

Description: The Vascular Study Group of Northern New England (VSG-NNE) is a voluntary, cooperative group of clinicians, hospital administrators, and research personnel organized to improve the care of patients with vascular disease. By collecting and exchanging information, the group strives to improve the quality, safety, effectiveness, and cost of caring for patients with vascular disease in Maine, New Hampshire, and Vermont. ■

Nursing Home Value-Based Purchasing Demonstration

Project No: HHSM-500-2005-00018I/01
Project Officer: Ronald Lambert
Period: September 2006 to September 2011
Funding: $1,400,000
Principal Investigator: Alan White
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The first stage of this project was refining the preliminary demonstration design. That phase is ongoing. We anticipate that the demonstration will begin in 2008, at which time the implementation support phase will begin.

Description: The Nursing Home Value-Based Purchasing (NHVBP) demonstration is part of a CMS Long Term Care Task Force initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing facilities. The purpose of the demonstration is to test the "pay for performance" concept for the nursing home setting prior to implementing NHVBP nationally. Under this demonstration, CMS will provide finiacial incentives to participating nursing homes that meet certain standards for providing high quality care. The demonstration will be financed from gains in efficiency. We will include all Medicare beneficiaries that are in a participating nursing home (i.e. those that receive Part A benefits as well as those that receive only Part B benefits). We estimate that 200 to 250 hospital-based and free-standing nursing homes in four or five States will participate. ■

Nursing Home/Assisted Living Facility Construction

Project No: 18-P-92331/8-01
Project Officer: Priya Helweg
Period: August 2004 to February 2007
Funding: $271,512
Principal Investigator: Tracey Fischer
Award: Grant
Awardee: Cheyenne River Sioux Tribe
P.O. Box 590
Eagle Butte, SD 57625

Status: The Administrator has been hired under Contract by the Cheyenne River Sioux Tribe and has developed the scope of services to be provided by the new LTC facility, being built with HUD funding. The facility is scheduled to open in November of 2007 and will serve Cheyenne River Sioux Tribal members. The facility will be a mixed services facility, meaning it will offer Senior living quarters, assisted living, and NH services.

Description: The purpose of the grant to the Cheyenne River Sioux Tribe (CRST) is to provide support to hire a Nursing Home Administrator. The Nursing Home Administrator will be developing the scope of services to be provided by CRST once the Nursing Home is built using funding from Housing and Urban Development (HUD). ■

Oklahoma SoonerCare Demonstration

Project No: 11-W-00048/06
Project Officer: Mark Pahl
Period: October 1995 to December 2009
Funding: $0
Principal Investigator: Mike Fogarty
Award: Waiver-Only Project
Awardee: Oklahoma, Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Status: The SoonerCare demonstration was approved for a three year renewal on December 21, 2006, and will run through December 31, 2009.

Description: The SoonerCare demonstration provides services to TANF related populations and the aged and disabled with some exceptions. In 2005, TEFRA children and working disabled and non-disabled low income workers were added as expansion populations. The demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the State to provide basic health care services. The program is partially capitated in that providers are paid a monthly capitated rate for a fixed set of services with non-capitated services remaining compensable on a fee-for-service basis. Primary objectives of the demonstration are to improve access to preventive and primary services, more closely align rural and urban providers, and instill a greater degree of budget predictability into Oklahoma's Medicaid program. ■

Oregon 1115 Independent Choices

Project No: 11-W-00130/00
Project Officer: Marguerite Schervish
Period: December 2001 to January 2008
Funding: $0
Principal Investigator: Genevieve Sundet
Award: Demonstration
Awardee: Oregon Senior and Disabled Services
500 Summer Street, NE
Salem, OR 97310-1015

Status: On January 26, 2007, CMS approved a one-year extension of the program, from February 1, 2007 until January 31, 2008, at which time the State's section 1115 program will expire. However, with the enactment of the Deficit Reduction Act of 2005, section 6087 (codified as section 1915(j) of the Social Security Act) permits States to offer self-directed personal assistance services (PAS) as part of their Medicaid State plans obviating the need for further waiver submissions. CMS understands that Oregon will pursue a section 1915(j) application to amend its State plan to add self-directed PAS.

Description: This is an 1115 demonstration that allows individuals who are eligible for

long-term care services to self-direct personal care and related services and to manage their cash allocation for these services. The program is available in three regions of the State for up to 300 consumers. This demonstration is similar in concept to the former approved Cash and Counseling demonstrations (now Independence Plus programs) in New Jersey, Florida, and Arkansas. The

main difference is that Oregon's demonstration did not employ a randomized or experimental design.

In addition, compared to Cash and Counseling, this demonstration requires all participants to manage their cash allowance. Monthly service allocations are paid directly into participants' Independent Choices checking accounts. Participants are responsible for deducting appropriate taxes and calculating employer payroll taxes. Participants pay their providers directly from their service allotment. A payroll service is available for participants who would like assistance and is required to be used by participants who have not passed a competency test to perform their fiscal responsibilities. The demonstration is less than Statewide and operates in three service areas with up to 100 participants enrolled in each site (Clackamas County, Coos/Curry Counties and Jackson/ Josephine Counties). The State indicates in its proposal that the selection of these three sites allows the State to evaluate the replicability of the model Statewide and to evaluate the program in both urban and rural settings.

Oregon's 1115 Independent Choices demonstration program was approved on November 22, 2000. Oregon submitted an amendment to allow payment to a participant's family, including the spouse of the participant. CMS approved the amendment on May 7, 2001. Oregon implemented the program on December 1, 2001. Current enrollment is about 300. On July 7, 2006, Oregon submitted a request to amend the program so it could operate statewide, and to extend the program. ■

Oregon Health Plan 2

Project No: 11-W-00160/00
Project Officer: Kelly Heilman
Period: October 2002 to October 2010
Funding: $0
Principal Investigator: Jim Edge
Award: Waiver-Only Project
Awardee: Oregon, Department of Human Services
500 Summer St, NE - E10
Salem, OR 97301-1076

Status: On October 31, 2007, the State received a 3 year extension for its OHP waiver, through October 31, 2010. As part of the extension, funding for higher income adults was switched from title XXI to title XIX.

Description: The Oregon Health Plan (OHP) combines an original Medicaid and SCHIP demonstration with a HIFA waiver, and includes 3 benefit packages: OHP Plus - mandatory populations including pregnant women and children up to 185 percent FPL; OHP Standard - expansion parents and childless adults/couples up to 185 percent FPL; and FHIAP - a premium assistance program offerred to OHP members with available ESI. Savings are used to extend health care coverage to various non-Medicaid populations, including higher income parents and caretaker relatives, and childless adults. The benefit packages for all three groups are based on a prioritized list of services, which is updated every two years by the Oregon Health Services Commission. Two variations of the prioritized list package are provided. Medicaid State plan populations receive OHP Plus, a richer set of services, while most expansion populations receive a reduced set of benefits in the OHP Standard program. FHIAP is the only benefit program available to eligibles with income above the FPL. ■

Outcome and Assessment Information Set (OASIS) Technical Analysis and Support Contract

Project No: 500-00-0026/02
Project Officer: Douglas Brown
Period: September 2002 to November 2006
Funding: $1,443,212
Principal Investigator: Andrew Kramer
Award: Task Order (MRAD)
Awardee: Center for Health Services Research, University of Colorado
13611 East Cofax Ave., Suite 100
Aurora, CO 80011

Status: The public reporting data support system was completed January 2003 to provide data for the Home Health Compare website. The contract was modified to provide continued support for the CMS public reporting effort, to provide additional technical and consultative support for the maintenance of the OASIS national reporting system and data repository and training in the collection of OASIS data, and to develop a web-based training program for Outcome Based Quality Improvement.

The Contract ended in November 30, 2006. Final deliverables included 9 process measures that are being transitioned and tested under new contract actions. No further entries will be made under this action.

Description: The purpose of this contract is to provide technical analysis and consultation to the Centers for Medicare & Medicaid Services (CMS) and its components on home health related projects using the

Outcome and Assessment Information Set (OASIS) and/or the Outcome Based Quality Improvement technique of quality improvement. The objective is to assist CMS to provide information that can be used to improve home health quality of care and also to design and implement a data analysis system to provide outcome data used for the public reporting of home health outcomes. Home health outcome information is derived from the analysis of data obtained from the collection and reporting by home health agencies of patient assessment information using OASIS. ■

Partnership for Early Childhood Health and Services

Project No: 18-P-93128/1-01
Project Officer: Lekisha Daniel-Robinson
Period: July 2005 to December 2007
Funding: $248,000
Principal Investigator: Michael Hastings
Award: Grant
Awardee: University of Maine
5717 Corbett Hall
Orono, ME 04469-5717

Status: In process.

Description: The objective of the project is to work with public and private programs statewide to develop voluntary systems for sharing information and knowledge regarding the background, needs, and experiences of children with developmental disabilities and their families while maintaining confidentiality and ensuring privacy. The result of this partnership will be a shared, population-based Developmental Disabilities Information System. ■

Partnership Plan, The

Project No: 11-W-00114/02
Project Officer: Camille Dobson
Period: July 1997 to September 2009
Funding: $0
Principal Investigator: Deborah Bachrach
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Corning Tower Building
Albany, NY 12237

Status: New York has submitted three requests to amend the demonstration. The first, approved November 16, 2007, added approximately 145 service codes to the list of services which may be claimed under the family planning expansion program. The second, approved December 31, 2007, added a premium subsidy component to Family Health Plus, where enrollees with access to cost-effective employer-sponsored insurance would be enrolled in that coverage rather than in direct Family Health Plus coverage. The third would provide 12 months of continuous eligibility for all Family Health Plus enrollees, as well as modify the asset test for farmers.

Description: The Partnership Plan Demonstration was approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations (Medicaid managed care program). In 2001, the Family Health Plus program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards. In 2002, the demonstration was further amended to provide family planning services to women losing Medicaid eligibility and certain other adults of childbearing age (family planning expansion program). Authority to mandate managed care enrollment for beneficiaries receiving SSI or otherwise aged or disabled as well as low-income families in 14 upstate counties was transferred to the Federal-State Health Reform Partnership (F-SHRP) demonstration in October 2006. The demonstration is funded by savings generated from the managed care delivery system. ■

Payment Development, Implementation Support, and Financial Monitoring for the Care Management of High Cost Beneficiaries Demonstration

Project No: 500-01-0033/03
Project Officer: Lawrence Caton
Period: May 2005 to November 2009
Funding: $2,481,308
Principal Investigator: C. William Wrightson
John Wilkin

Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The total funding was increased and will cover payment for the contractor's performance of work through April 9, 2008.

Description: This task order supports the Centers for Medicare and Medicaid Services (CMS) in implementing approximately six regional programs to provide care management services to high cost Medicare fee-for-service beneficiaries under the Care Management for High-Cost Medicare Beneficiaries Demonstration (CMHCB). The assumption is that 8,000 beneficiaries will be placed in an intervention group and 8,000 in a control group for each of the 6 programs, yielding 80,000 to 120,000 beneficiaries for ongoing analysis. ■

Payment Development, Implementation, and Monitoring for the BIPA Disease Management Demonstration

Project No: 500-00-0036/02
Project Officer: Juliana Tiongson
Period: September 2004 to September 2009
Funding: $1,383,158
Principal Investigator: C. William Wrightson
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: Using information suppled by LifeMasters, the contractor developed monthly rates for the project. The contractor is providing the projects with Medicare claims information on the beneficiaries that are enrolled in this disease management treatment group on a regular basis. The contrator also provides the project with summary information relating to Medicare claims for the control group. The contractor monitors the Medicare claims for both treatment and control groups and on a quarterly basis provides a detailed analysis to CMS and the project for monitoring their progress in maintaining budget neutrality.

Previously under this contract, the contractor provided the same analysis and monitoring support for the BIPA Disease Management Demonstration which ended in 2006.

Description: The purpose of this task order is to provide support to the Centers for Medicare & Medicaid Services (CMS) in implementing and monitoring demonstrations projects that provide disease management services to Medicare beneficiaries. These demonstrations include the LifeMasters Disease Management Demonstration for dually-eligible Medicare beneficiaries, and several other disease management demonstrations that are in the planning stages.

Under this task order, the major tasks are:

1. Providing general technical support to CMS in the analysis of rate proposals and assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects;

2. Educating of demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements;

3. Monitoring payments and Medicare expenditures to assure budget neutrality, including designing data collection processes for use in collecting and warehousing necessary data elements from sites and CMS administrative records for assessing performance; and

4. Performing financial analysis to assist in the financial settlement and reconciliation. ■

Payment Development, Implementation, and Monitoring Support for the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management Demonstrations

Project No: 500-00-0036/01
Project Officer: J. Sherwood
Period: September 2002 to September 2007
Funding: $435,557
Principal Investigator: C. William Wrightson
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: Using information suppled by the sites, the contractor developed monthly rates for the three BIPA demonstration projects. The contractor provided the projects with Medicare claims information on the beneficiaries that are enrolled in the Disease Management treatment group on a regular basis. The contrator also provided summary information relating to Medicare claims for the control group. The contractor monitored the Medicare claims for both treatment and control

groups and on a quarterly basis provided a detailed analysis to CMS and the projects for monitoring their progress in maintaining budget neutrality. The project is now complete.

Description: The purpose of this task is to support CMS in implementing a demonstration project in three or more sites to provide disease management services to Medicare beneficiaries with advance stages of congestive heart failure, coronary heart disease, and/or diabetes. Specifically, this project 1) provides general technical support in the analysis of rate proposals and assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects; 2) educates demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements; 3) monitors payments and Medicare expenditures to assure budget neutrality, including designing data collection processes for use in collecting and warehousing necessary data elements from sites and CMS administrative records for assessing performance; and 4) performs financial analysis to assist in the financial settlement and reconciliation. ■

Payment, Data Management, Implementation, and Monitoring Support for the Medicare Care Management Performance Demonstration

Project No: 500-00-0036/03
Project Officer: Jody Blatt
Period: September 2004 to September 2008
Funding: $1,777,854
Principal Investigator: John Wilkin
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The demonstration is operational and started its first performance year July 1, 2007. Approximately 700 small to medium sized physician practices are participating.

Description: This 3 year demonstration was mandated under Section 649 of the MMA to promote the use of health information technology and improve the quality of care for beneficiaries. Doctors in small to medium sized practices who meet clinical performance measure standards will receive a bonus payment for managing the care of eligible Medicare beneficiaries. The demonstration will be implemented in California, Arkansas, Massachusetts and Utah.

The purpose of this particular contract is to support CMS in implementing the Medicare Care Management Performance (MCMP) demonstration project and providing technical and administrative support to CMS in management of data and payment incentives to participating physician practices. ■

Performance Monitoring of Voluntary Chronic Care Improvement Under Traditional Fee-For-Service Medicare.

Project No: 500-00-0033/08
Project Officer: Pamela Cheetham
Louisa Rink
Period: February 2005 to July 2009
Funding: $6,059,875
Principal Investigator: Sue Felt-Lisk
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: This pilot project is now called Medicare Health Support (MHS). Recently, the contract was modified to provide incremental funding. It is estimated that the funding allotted to the contract will cover performance through July 31, 2009.

Description: The performance-monitoring task order provides the means to monitor Medicare Health Support operations and collect data needed to track clinical performance of participating disease managment organizations and utilization of health resources by the intervention and control groups during Phase I of this pilot project. The monitoring process is dependent upon collaboration among several contractors, CMS, and the Medicare Support Organizations (MHSOs) to ensure the specification, collection, storage, and reporting of accurate clinical data for Medicare beneficiaries in the intervention and control groups - particularly intervention group beneficiaries actively participating in MHS. Data support the efforts of the individual MHSO as well as the independent evaluator. Comparative data will help to inform a decision by the Secretary on potential program expansion, as specified in Section 721 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. ■

Performance Reporting and Administrative Support of CMS's Medicaid Grant Initiatives

Project No: HHSM-500-2006-00100G
Project Officer: Ronald Hendler
Period: August 2006 to August 2011
Funding: $4,136,754
Principal Investigator: Jessica Kahn
Award: GSA Order
Awardee: Ascellon Corporation
8201 Corporate DriveSuite 950
Landover, MD 20785

Status: A contract Modification and execution of an Optional Task was executed in the amount of $357,813. The Modification was to add the 28 new Real Choice Grants and increase the expected attendance at the MIG conference from 110 to 200. The Optional Task, Product Inventory for DMIE Grants, is now an official task.

The Contractor is completing the contract tasks on time, effectively and efficiently.

Description: The purpose of this Task Order is to provide support to the Centers for Medicare and Medicaid Services (CMS) project officers that programmatically manage grants in the CMS Disabled and Elderly Health Programs Group (DEHPG) and the grant specialists, who are the principal administrators of the grant, in the CMS Office of Acquisition and Grants Management (OAGM).

The pertinent grans and demonstration are:

o Medicaid Infrastructure Grants (MIG;

o Demonstration to Maintain Independence & Employment (DMIE); and

o Real Choice Systems Change Grants - Fiscal YEars 2002-2006 ORCSC). ■

Physician Referral Patterns to Specialty Hospitals

Project No: 500-00-0024/12
Project Officer: Philip Cotterill
Period: July 2004 to August 2007
Funding: $1,030,634
Principal Investigator: Jerry Cromwell
Kathleen Dalton
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The final report is available on the CMS website at http://www.cms.hhs.gov/reports/downloads/cromwell3.pdf

An update of the tables in the original report will be made using 2004 data. A supplemental report that compares ASC and OPPS pricing for orthopedic and surgery hospitals will be available in Fall 2006 on the CMS website. The report on potential improvements in hospital payment accuracy (by refining cost-to-charge ratios) is available on the CMS website at http://www.cms.hhs.gov/reports/downloads/Dalton.pdf.

Description: The purpose of this project is to conduct a study of the referral patterns and benefits of speciality hospitals as required under section 507 of the MMA. The study will be used to help determine whether the 18-month moratorium (which expires June 2005) on physician referrals to specialty hospitals in which they hold an ownership interest should be lifted, extended, or made permanent. In its final phase, the study investigated potential improvements in hospital payment accuracy that might alter incentives for specialty hospitals concentrating on certain inaccurately priced DRGs. ■

Post Acute Care Payment Reform Demonstration: Project Implementation and Analysis.

Project No: HHSM-500-2005-00029I/05
Project Officer: Shannon Flood
Period: February 2007 to December 2010
Funding: $1,800,000
Principal Investigator: Barbara Gage
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This project is in Phase I of development. Relevant data collection instruments have been developed, tested, and are currently in the midst of

the OMB-PRA clearance process. Markets are being selected and recruited in preparation for data collection.

Description: As a component of the Deficit Reduction Act of 2005 (S1932.Title V.Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). PAC-PRD will examine acute care hospitals and four types of PAC providers: Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). Work on the PAC-PRD is divided into three contracts. This task order comprises the third, implementation and analysis of the demonstration. This task order is broken into two phases. Phase I includes tasks relating to the development of the demonstration including creating analysis plans, determining how cost and resource use (CRU) shall be collected, recruitment of facilities, and a limited roll out of the demonstration in one referral network. Phase II includes data collection using the newly developed instruments, analysis of the data and report writing. Analysis topics include payment reform recommendation, predicting resource utilization, predicting discharge placement, and predicting outcomes. The Mandate/Authority of this contract is the Deficit Reduction Act of 2005. ■

Post-Acute Care: Patient Assessment Instrument Development

Project No: HHSM-500-2005-00029I/04
Project Officer: Judith Tobin
Period: November 2006 to December 2010
Funding: $2,974,753
Principal Investigator: Barbara Gage
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The contract was modified to increase the level of effort under Tasks 5 and 15. The contractor's technical proposal entitled "Post Acute Care: Patient Assessment Instrument Development" dated August 8, 2007 was incorporated by reference and made a part of the task order.

Description: This task order will design and complete the development of the assessment instrument required by the 2005 Deficit Reduction Act (DRA). In general, this will involve designing, developing and organizing questions and instructions that direct the collection of the patient assessment data relevant to assessing function, clinical status, quality of care, use of resources and related purposes. The instrument will initially be documented on a usable paper-based format for review, reference, and potential interim use, but shall be designed to be an internet-based instrument that is interoperable across provider settings. ■

Practice Expense Methodology

Project No: 500-2004-00054C
Project Officer: Kenneth Marsalek
Period: September 2004 to December 2008
Funding: $385,626
Principal Investigator: Allen Dobson
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: CMS is no longer accepting supplementing survey data. The AMA is planning a survey of physician practices. CMS staff and the contractor met with AMA staff to discuss various approaches to surveying non-physician practitioners to obtain practice expense data. The contractor's technical proposal dated September 12, 2007 was incorporated and made a part of this contract. The Period of Performance was extended through December 31, 2008.

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.

- 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 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 established a Practice Expense Review 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. ■

Premier Hospital Quality Incentive Demonstration

Project No: 500-00-0015/02
Project Officer: Linda Radey
Period: September 2004 to September 2008
Funding: $999,970
Principal Investigator: Stephan Kennedy, Ph.D.
Kevin Coleman
Cheryl Damberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project is in its fourth and final year. The demonstration was recently extended an additional three years.

Description: This project is to evaluate the impact of the Premier Hospital Quality Incentive (HQI) Demonstration on the changes in the quality and cost care for five prevalent inpatient diagnoses. Under the demonstration, CMS will reward top-performing hospitals in each year of the demonstration. CMS has the potential to penalize hospitals in the third year of the demo that perform below an absolute level of quality that will be established after the first year. ■

Premier Hospital Quality Incentive Demonstration (HQID)

Project No: 95-W-00103/04
Project Officer: Katharine Pirotte
Period: October 2003 to September 2009
Funding: $0
Principal Investigator: Diana Jackson
Award: Waiver-Only Project
Awardee: Premier Healthcare Informatics
2320 Cascade Pointe Boulevard, Suite 100
Charlotte, NC 28208

Status: The demonstration involves a CMS partnership with Premier, Inc. a nationwide organization of not-for-profit hospitals that operates a quality measurement system. The demonstration began on October 1, 2003 with 278 Premier hospitals. The Medicare payments of the incentive bonuses for year 1 was about $8.85 million and $8.69 million for year 2. The average composite quality score and the aggregate of all quality measures within each clinical area improved significantly since the inception of the program in all 5 clinical focus areas. These clinical areas are acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacement. An extension of the HQID was approved from fiscal year 2007 through fiscal year 2009. The most notable changes in the extended demonstration are in the payment methodology, which includes incentives for quality improvement as well as for achieving high quality. The objectives are to test new payment models, ways to measure quality, and methods to support designing CMS value-based purchasing models.

Description: The purpose of the demonstration is to determine the effectiveness of improving the quality of inpatient care for Medicare beneficiaries by awarding quality incentive payments to hospitals for high quality in several clinical areas, and by reporting extensive quality data on the CMS Web site. ■

Prescription Drug Coverage in Medicaid: Using Medicaid Claims Data to Develop Prescription Drug Monitoring and Analysis

Project No: 500-00-0047/02
Project Officer: David Baugh
Period: September 2002 to July 2008
Funding: $1,172,286
Principal Investigator: Jim Verdier
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has prepared a full set of data tables in the form of a statistical compendium, using MAX data for the 50 States and Washington, D.C. The tables provide detailed information on prescription drug utilization and spending for three major populations: all Medicaid, dual enrollees and Medicaid nursing facility residents. The contractor has also produced a Chartbook "Medicaid Pharmacy Benefit Use and Reimbursement". The tables and chartbook are available for 1999, 2001 and 2002. These products are available on the CMS web site data:

http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp#TopOfPage

Work is under way to produce the Statistical Compendium and Chartbook using 2003 and 2004 MAX data.

This contract has also produce research papers. One paper has been published and others are in review. The publication reference is:

Bagchi, A., Esposito, D., and Verdier, J.: Prescription Drug Use and Expenditures Among Dually Eligible Beneficiaries. *Health Care Financing Review*, Summer 2007, Vol. 28, No. 4, pages 43-56.

Description: Rapid growth in Medicaid prescription drug expenditures, serious State budget problems, and the congressional debate on Medicaid prescription drug coverage have combined to draw increasing attention to prescription drug use in Medicaid. The new Medicaid Analytic eXtract (MAX) database for 1999 provides an opportunity to develop tables, graphs, and analyses that can illuminate these prescription drug issues for Federal and State policymakers, stakeholder groups, and researchers at a level of detail not readily available to date. This contract uses the MAX data to address Medicaid and Medicare prescription drug issues. ■

Produce and Disseminate Program Statistics from Section 723 Chronic Conditions Warehouse (CCW)

Project No: HHSM-500-2006-00008I/01
Project Officer: Spike Duzor
Period: August 2006 to August 2008
Funding: $1,096,074
Principal Investigator: Wendy Funk
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project is ongoing.

Description: The task order will produce and disseminate program statistics derived from the Section 723 chronic condition data warehouse (CCS). These program statistics will be used to help improve the quality of care and reduce the cost of care for chronically ill Medicare beneficiaries as requried by Section 723 of the Medicare Modernization Act. The objectives are two-fold: 1) to evalue the robustness of the CCW for research purposes. The contractor shall address the strengths and weakensses of the CCW; and 2) to create program statistics based on the contractor's analyses of the CCW. The analyses from the first objective should create a "blue print" of what statistics the CCW is capable of supporting. These newly created statistics should address emerging themes in chronic disease, such as preventive management, quality outcomes, and disease management. ■

Program to Enhance Medicaid Access for Low Income HIV-Infected Individuals in the District of Columbia (DC HIV/AIDS 1115 Demonstration)

Project No: 11-W-00131/03
Project Officer: Camille Dobson
Period: January 2001 to January 2010
Funding: $0
Principal Investigator: Robert Maruca
Award: Waiver-Only Project
Awardee: District of Columbia, Department of Health
825 N. Capitol St, NE
Washington, DC 20012

Status: The Demonstration has been implemented and is operational. One hundred forty-five individuals were enrolled as of June 30, 2007.

Description: This demonstration expands Medicaid coverage to HIV-positive individuals. Participants receive most services through an unrestricted fee-for-service delivery system, but are limited in their choice of pharmacy provider. The demonstration is funded by savings generated from the District purchasing HIV/AIDs drugs from the Department of Defense, rather than through the regular Medicaid program. ■

Programmatic Technical Assistance to the Grantees Under the Demonstration to Improve the Direct Service Community Workforce

Project No: 500-00-0051/04
Project Officer: Kathryn King
Period: October 2004 to September 2007
Funding: $351,326
Principal Investigator: Lisa Maria Alecxih
Award: Task Order (RADSTO)

Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: The Contractor provided programmatic TA to grantees on regular basis, posted relevant materials on the DSW website for grantees it created, and held bi-monthly calls for all grantees and topical calls by grantee-intervention type. The also developed written products based on the DSW Intensive activity at the NFI conference. The project is now complete.

Description: The purpose of this project is to provide funding for a project that will provide programmatic technical assistance to the ten grantees in the Demonstration to Improve the Direct Services Community Workforce. ■

Programming Support for the Evaluation of the MMA Section 641(e) Demonstration Program

Project No: 500-02-0006/05
Project Officer: Penny Mohr
Period: February 2005 to February 2007
Funding: $99,899
Principal Investigator: Celia H. Dahlman
Award: Task Order (ADP Support)
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

Status: Analyses of spending patterns for the 8 months prior to the start of the demonstration have been completed and were included in the Report to Congress, available on the CMS website at http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA641_RTC.pdf. A follow-on study of the transition of participants with rheumatoid arthritis and multiple sclerosis to Medicare Part D is underway. The contract for programming support for this study ended February 2007.

Description: Provide programming support for the evaluation of the Section 641 Demonstration Program. This demonstration, also known as the Medicare Replacement Drug Demonstration, provides Medicare coverage for selected oral and self-injectable drugs not previously covered under Medicare Part B. One aspect of the evaluation will be an analysis of patterns of health care spending on costs for patients covered under the demonstration. This task order is to obtain programming services to create person-level analytic files linking across Medicare claims and Medicare enrollment databases. ■

Programming Support for Utilization and Cost Studies Using the SEER-Medicare Database

Project No: 500-02-0006/04
Project Officer: Gerald Riley
Period: September 2004 to September 2008
Funding: $199,987
Principal Investigator: Celia H. Dahlman
Award: Task Order (ADP Support)
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

Status: The contractor has prepared several analytic files related to various projects for CMS, NCI, and NCI contractors.

Description: This project provides programming support for research projects involving the Surveillance, Epidemiology, and End Results (SEER)-Medicare database. The SEER-Medicare database has been in existence since 1991 and is the collaborative effort of the National Cancer Institute (NCI), the SEER registries, and CMS to create a large population-based source of information for cancer-related epidemiologic and health services research. The linked database combines clinical data on incident cancer cases from SEER with Medicare claims and enrollment information.

Investigators from both CMS and NCI use SEER-Medicare for studies of patterns and costs of cancer care. The purpose of this contract is to provide programming support for such studies through the creation of analytic files and development of statistical programs.

CMS and NCI are both providing funds for this effort. ■

Public Reporting and Provider and Health Plan Quality of Care

Project No: 500-00-0024/14
Project Officer: David Miranda
Period: September 2003 to June 2007
Funding: $1,403,571
Principal Investigator: Shulamit Bernard
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Qualitative research on the potential role of Geriatric Care Managers as information intermediaries around nursing home and home health quality is complete. Qualitative research on the role of physicians as intermediaries for patients around hospital quality data is complete. A survey of physicians on the impact of CMS's Hospital Compare website is in the field.

Description: The Balanced Budget Act of 1997 mandated that CMS provide beneficiaries with information to make better health plan choices, including information about the quality of care provided by health plans (see www.medicare.gov/mphCompare/home.asp and Volume 23, Number 1 [www.cms.hhs.gov/review/01fall/default.asp] and Volume 22, Number 3 [www.cms.hhs.gov/review/01spring/default.asp] of the *Health Care Financing Review*). Since that time, CMS has expanded these efforts in at least three areas. We have begun to look at the particular needs of vulnerable populations for information about quality of care and help them make choices. We have also expanded the scope of quality of care information to include information about providers such as dialysis facilities, nursing homes, home health agencies, and hospitals (see www.medicare.gov/NHCompare/home.asp, www.cms.hhs.gov/researchers/projects/APR/09-theme7.pdf, Volume 23, number 4, of the *Health Care Financing Review* [www.cms.hhs.gov/review/02summer/default.asp], and, for hospital information, www.dfmc.org/html/hiw/). Finally, we have also expanded in the area of supporting infrastructure for informed choice (see www.cms.hhs.gov/researchers/projects.asp). That is, CMS has launched the 1-800-Medicare call center and the Medicare Personal Plan Finder (see www.medicare.gov/MPPF/home.asp) in addition to supporting the role of State Health Insurance Assistance Programs in counseling beneficiaries about health plan choices. Similarly, the Quality Improvement Organizations have begun addressing the roles that discharge planners, physicians, nurses, social workers, and others play in supporting the decisions that patients and their caregivers make about providers. Physicians are a particularly interesting group in that they are not only information. ■

Public Reporting of Part D

Project No: HHSM-500-2006-00006I/03
Project Officer: Chris Powers
Period: August 2006 to December 2008
Funding: $657,382
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: A revised Statement of Work entitled, "Evaluation of Part D Sponsors' Low-Income Subsidy Match Rate" along with a revised schedule of deliverables were incoporated by reference, and made a part of the task order in September 2007. The period of performance was extended, funded in the amount of $134,457, and two option years were added.

Description: This task order will develop the method to collect the LIS data from the plans, design a data collection instrument and process, communicate with plans regarding the submission of LIS data, access the CMS LIS data and then compare and analyze the files and report the LIS match rate back to CMS. The contractor shall work with the GTL to ensure a complete understanding of the LIS files and the LIS related analysis and reports required by CMS. ■

Public Reporting of Provider Quality

Project No: HHSM-500-2006-00009I/01
Project Officer: David Miranda
Period: July 2006 to June 2009
Funding: $3,001,720
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The Contractors technical proposal entitled "Public Reporting of Provider Quality: Research and Testing," dated July 23, 2007, the Contractor's responses to CMS technical questions dated September 4, 2007, and the Contractor's technical proposal entitled "Public Reporting of Cost & Volume: Website Audience Testing," dated September 20, 2007, were incorporated by reference and made a part of this task order.

Description: This task order requires the Contractor to plan and conduct qualitative testing with patients, other consumers and clinicians on new measures for the Hospital Compare, Home Health Compare, and potentially other "Compare" tools, such as Nursing Home Compare. The Contractor shall also conduct qualitative testing on measures for the Medicare Prescription Drug Plan Finder and to potentially add to the Medicare Physician Finder. ■

Quality Indicator Survey (QIS) Training And Analysis

Project No: 500-00-0052/01
Project Officer: Karen Schoeneman
Period: July 2005 to September 2008
Funding: $3,308,154
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The contract was modified to increase the level of effort, and revise the Statement of Work and Schedule of Deliverables. The period of performance was extended to September 2008. The total funding was increased by $1.1 million dollars. The contractor has assisted in the completion of an evaluation of the QIS demonstration by a separate contractor, and now is engaged in assisting CMS with updates to the QIS process and training materials, and development of extra features including other survey process types (revisit, complaint evaluation, extended survey, and federal monitoring), as well as a desk audit for use by survey supervisors and CMS regional offices.

Description: The Quality Indicator Survey (QIS) is a revised long-term care survey process that was developed under Centers for Medicare & Medicaid Services (CMS) oversight through a multi-year contract. The QIS was designed as a staged process for use by surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review. The QIS provides a structure for an initial review of larger samples of residents based on the MDS, observations, interviews, and medical record reviews. Utilizing onsite automation, survey findings from the first stage are combined to provide rates on a comprehensive set of Quality of Care Indicators (QCIs) covering all resident- and facility-level federal regulations for nursing homes. The second stage then provides surveyors the opportunity to focus survey resources on further investigation of care areas where concerns exist. In this follow-on contract, the contractor ran a demonstration of the QIS in 5 States (recently completed), and has been providing training to additional State surveyors, developing and providing a course to train State trainers, and as completing various analysis and monitoring activities, as the QIS moves to wider implementation. ■

Rationalize Graduate Medical Education Funding

Project No: 18-C-91117/08
Project Officer: Siddhartha Mazumdar
Period: February 2000 to June 2010
Funding: $839,875
Principal Investigator: Gar Elison
Award: Cooperative Agreement
Awardee: Medical Education Council
230 South 500 East, Suite 550
Salt Lake City, UT 84102-2062

Status: The Council's goals are to ensure that Utah's clinical training programs are producing the number and types of health professionals needed in the State and to stabilize and ensure the continuation of residency positions and programs. A regional planning method that surveys the population's health professional needs is intended to result in a more equitable distribution of resources. The grant is now fully funded.

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. ■

Refinements to Medicare Diagnostic Cost Group (DCG) Risk-Adjustment Models

Project No: 500-00-0030/04
Project Officer: Jesse Levy
Period: September 2002 to September 2007
Funding: $1,028,631
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Status: The contract has ended. Data from 2002 and 2003 have been used to develop a new, more refined version of all the components of the HCC model with more disease classes. A much larger sample of institutionalized were included for that segment of the model and an update of the ESRD HCC model has been produced. The work improved predictions for segments of the population with special needs. A final report was not required for this project.

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations was developed under contract with CMS (#500-92-0020 Task Order 6) and were then further improved (#500-95-0048 Task Order 3). This task order will test the model for use in special populations to develop satisfactory payment for plans that enroll beneficiaries selectively based on their medical, functional, or institutional condition. The DCG-based models are designed to use demographic and diagnostic information to project expenditures and to provide factors that could be used to multiply the ratebook amounts instead of the demographic factors currently used.

Further work is to be done on a concurrent model and on an institutional model using a larger sample. The ICD-9 tables will be updated to reflect coding changes to keep the model responsive to new codes. ■

Refining Cost to Charge Ratios for Calculating APC and DRG Relative Payment Weights

Project No: HHSM-500-2005-00029I/08
Project Officer: Philip Cotterill
Period: August 2007 to August 2008
Funding: $285,963
Principal Investigator: Kathleen Dalton
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The project is in progress. An Interim Report is due in mid-January 2008.

Description: This task order will develop regression models for selected hospital ancillary departments based on both inpatient and outpatient charges. Further, the task order will extend the model to estimate CCR adjustment factors for service groups particularly relevant to the OPPS. It will also explore methods of circumventing inherent limitations of the regression appraoch to widen its applicability to the OPPS. ■

Research Data Assistance Center (ResDAC) - II

Project No: 500-01-0043
Project Officer: Spike Duzor
Period: September 2001 to September 2008
Funding: $7,080,259
Principal Investigator: Marshall McBean
Award: Contract
Awardee: University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Mail Code Number 99
420 Delaware Street SE, D 355 Mayo Building
Minneapolis, MN 55455

Status: The contract has been extended to September 2008. Within the last year, the total funding of this contract has increased to $939,000.

Description: This project assists researchers who are not familiar with the data available at CMS. It describes the data and helps them with the process of gaining an approved Data Use Agreement. It also conducts training classes for these new-to-CMS researchers. This project will provide: technical on-site analytic support and training in accessing administrative and claims databases, linking databases, and creating analytic databases; training modules for data access and use by external organizations/researchers; and consultative and data support functions for governmental and non-governmental research.

This is a follow-on award from a competitive procurement, to the incumbent contractor. It will be incrementally funded over its life. Thus, this award continues the work of the first ResDAC contract, 500-96-0023. ■

Research Data Distribution Center

Project No: 500-01-0031/01
Project Officer: Terry Maddox
Period: June 2005 to December 2008
Funding: $3,925,469
Principal Investigator: Damien Marston
Kim Elmo
Award: Task Order (ADDSTO)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The period of performance was extended through December 31, 2008. Special Invoice Requirements Pursuant to the requirements of Task 5, "Track and Report Information on Customer Orders" of the Statement of Work, the Contractor will submit monthly invoices to include: 1) a total accounting of all reimbursable charges for both private researchers and Federal agencies 2) a separate total breakout of all reimbursable charges for private researchers 3) a separate breakout of all reimbursable charges for each of the Federal agencies provided data, and 4)a total cumulative reimbursable charges by private researchers and each Federal agency.

Description: This task order will serve as a pilot test of the concept of a CMS data distribution center. This Contractor will function as the single point of contact for public and private researchers seeking access to CMS program enrollment data, Medicare claims data, and Medicaid research files. Using the information gained from the pilot, CMS anticipates a future competitive contract to operate one or more data distribution centers on an ongoing basis. ■

Research on System Change for Community Living

Project No: 500-00-0044/02
Project Officer: Cathy Cope
Period: September 2001 to September 2008
Funding: $3,979,996
Principal Investigator: Janet O'Keefe
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (DC)
1615 M Street, NW, Suite 740
Washington, DC 20036-3209

Status: This project has been extended for an additional year with a no-cost extension in order for contractor to complete final reports of grants. Most of the RCSC Grants have been extended for an additonal year and this project includes the final analysis and reports for all the grants that began between 2001 and 2004. The first Final report for Grants that ended in 2004 and 2005 was released. The contract was recently modified to revise the schedule of deliverables to add the following topic paper: Topic paper #08 - Accomplishments and challenges of the Grantees focused on quality assurance and quality improvement initiatives. A draft of the paper would be submitted by January 2008, and the final topic paper is due by Febuary 28, 2008.

Description: The Center for Medicare and Medicaid Services (CMS) has awarded a number of Systems Change Grants for Community Living. The goal of this related project is to conduct both formative and summative evaluation activities. The project will capture relevant data about:

• The target populations selected by the grantees for systemic change activities;

• The specific long-term care needs of the populations to be addressed in systems change activities;

• The similarities and differences between methods selected by grantees to address the needs identified in their State;

• The challenges and barriers faced by grantees in addressing the long-term care needs of their selected populations;

• The changes made in the provision of long-term care in the grantee States as a result of the activities of the grantees;

• The factors influencing environments to create successful systems change.

The project will also establish the initial framework and foundation for future summative evaluation activities, including:

• Outcome evaluations to measure whether the Systems Change Grants have caused demonstrable effects;

• Impact evaluation – to assess the net effects both intended and unintended of the Systems Change Grants;

• Value evaluation – to examine the cost effectiveness of systems changes, the individual value to the consumer in the promotion of dignity, independence, individual responsibility and choice, and self-direction, as well as the value to the community.

Specifically, the project will:

(1) Collect, analyze and evaluate data from the systems change activities of Systems Change Grantees regarding:

(a) the extent of effectiveness and impact of consumer involvement in programmatic design, implementation and evaluation;

(b) the types of direct services provided using grant funds, including the amount, duration and scope of services provided;

(c) the types of changes made in State Medicaid Programs to achieve enduring systems change;

(d) the changes in delivery of long-term services and supports and payment systems under State Medicaid Programs and other funding streams;

(2) Evaluate innovative systems and methods for delivery of community-based long-term care services and supports;

(3) Perform research to assess the need for structural reforms of State Medicaid Programs, and other Federal programs supporting long-term care;

(4) Develop tools for measuring changes in access, availability, quality, and value of community-based long-term care;

(5) Develop improved information resources to assist consumers and their representatives in choosing long-term care providers and supports;

(6) Evaluate new payment and delivery models to improve access, availability, quality, and value of community-based long-term services and supports for children and adults of any age with a disability or long-term illness.

(7) Prepare reports and presentations for CMS and other audiences based upon specified analysis. ■

Rhode Island RIte Care

Project No: 11-W-00004/01
Project Officer: Camille Dobson
Period: November 1993 to July 2008
Funding: $0
Principal Investigator: John Young
Award: Waiver-Only Project
Awardee: Rhode Island, Department of Human Services, HCQFP, Center for Adult Health
600 New London Avenue
Cranston, RI 02920

Status: The State submitted a request for extension of this demonstration and it is currently under review.

Description: The Rhode Island RIte Care demonstration is a statewide program that delivers primary and preventive health care services for all Family Independence Program families (formerly known as AFDC families) and certain low-income women and children through a fully capitated managed care delivery system. The Demonstration also includes RIte Share, a premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI). Under RIte Share, the State pays all or part of an eligible family's monthly premium, based on income and family size, for an employer's Department of Human Services (DHS)-approved ESI. RIte Share provides coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments. Finally, the State provides replacement windows in the homes of lead-poisoned children enrolled in the demonstration. ■

Rural Hospice Demonstration: Quality Assurance Metrics Implementation Support

Project No: HHSM-500-2005-00034C
Project Officer: Cindy Massuda
Period: September 2005 to September 2008
Funding: $372,496
Award: Contract
Awardee: HCD International, Inc.
4390 Parliament Place
Lanham, MD 20706-1808

Status: Option year.one was exercised. The period of performance was exented to September of 2008.

Description: The purposes of the Rural Hospice Demonstration contract for quality assurance support for two demonstration hospices are: 1) Quality Measure Identification and Template Development to achieve standard formats and consistent data collection; 2)Analysis to verify and validate data submitted and to evaluate the usefulness and appropriateness of domains, measure, elements, templates, education strategies, and performance improvement projects; 3) Provider Education to assist the demonstration sites with on-going quality metrics education through the use of CD-ROMs, manuals, and other sources to develop the concept of quality through the hospice program; and 4) Quality Improvement Program Implementation Support to assist demonstration sites in evaluating effectiveness of performance improvement projects and revision, as necessary. ■

SacAdvantage Health Insurance Subsidy Program

Project No: 18-P-91851/09-01
Project Officer: Carl Taylor
Period: September 2003 to September 2007
Funding: $695,450
Principal Investigator: Amerish Bera
Award: Grant
Awardee: County of Sacramento, Dept. of Health & Human Resources
7001A East Parkway, Suite 500
Scaramento, CA 95823

Status: This grant was conducted during the period September 30, 2003 through September 29, 2007. The project has now expired.

Description: The County of Sacramento conducted a health insurance premium subsidy program for low-income employees and dependents. This pilot program addressed the health access needs of these individuals through a health insurance premium subsidy program called SacAdvantage. SacAdvantage utilized the services of an existing statewide small employer health insurance purchasing pool, PacAdvantage, to provide choice of health plan, simplicity of administration, and bargaining leverage in the health care market. Funds in the project were used for direct payment of premium subsidies for qualifying low-income employees of small employers. ■

Safety Net Benefit Program

Project No: 11-W-00214/06
Project Officer: Mark Pahl
Period: March 2006 to September 2011
Funding: $0
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services
Division of Medical Services
PO Box 1437, Slot S401
Little Rock, AR 72203-1437

Status: The Safety Net Benefit Program was implemented October 1, 2006 and will run through September 30, 2011.

Description: Arkansas' HIFA initiative, the Arkansas Safety Net Benefit Program, provides a "safety net" benefit package through a public/private partnership for uninsured individuals with incomes at or below 200 percent FPL. ConnectCare, the State's PCCM program formerly operated under 1915(b) authority, also has been subsumed into this demonstration. ConnectCare is mandatory for TANF, TANF-related, SSI and SSI-related populations. Services provided under the safety net benefit package are delivered through the NovaSys Health provider network. The ConnectCare population continues to receive services through the State's ConnectCare PCCM Program network of providers. The objective of the demonstration is to target and assist uninsured low-wage employees of small businesses in Arkansas. ■

Sample Design and Data Analysis of the Medicare Health Plan CAHPS Surveys

Project No: HHSM-500-2005-00028I/02
Project Officer: Amy Heller
Period: September 2006 to September 2008
Funding: $4,620,604
Principal Investigator: Marc Eliott
Award: Task Order (MRAD)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The base year of the contract has ended and option year one has started. The funding has increased due to inflation by $100,000. Additional funding was provided due to an increased level of effort under Option Year 1.

Description: This task order will implement sample design, data analysis and reporting for the Medicare Consumer Assessments of Health Providers and Systems (CAHPS) Surveys among samples of persons with Medicare in Medicare Advantage (MA) for both enrollees, Medicare Fee-For-Service (FFS), and Medicare. ■

Second Generation Social Health Maintenance Organization Demonstration: Health Plan of Nevada

Project No: 95-W-90503/09
Project Officer: Dennis Nugent
Period: November 1996 to December 2007
Funding: $0
Principal Investigator: Ronnie Grower
Award: Waiver-Only Project
Awardee: Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, NV 89114-5645

Status: The project's final Report to Congress was released by the Secretary of Health and Human Services in February 2003. The purpose of this report was to present an analysis of the S/HMO II model. The S/HMO demonstration ended on December 31, 2007.

Description: The purpose of the second-generation social health maintenance organization (S/HMO-II) demonstration was to refine the targeting and financing methodologies and the benefit design of the original S/HMO model. The S/HMO integrated health and social services under the direct financial management of the provider of services. All acute and long-term-care services were provided by or through the S/HMO at a fixed capitation payment. The S/HMO-II provided an opportunity to test a model of care focusing on geriatrics. The Health Plan of Nevada (HPN) was the only one of the six organizations selected to participate in the project to implement the demonstration.

The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 continued the demonstration until 18 months after the Secretary submitted the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended the demonstration until 30 months after the S/HMO Transition Report to Congress was submitted. This report addressed transitioning S/HMOs and similar plans to the Medicare+Choice program. The report was sent to Congress in February 2001. Under its discretionary authority, CMS extended the demonstration two more times through December 31, 2007. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. In 2005 through 2007, the demonstration's payment methodology was based on a 70/30, 50/50, and 25/75 percent blend, respectively. A frailty adjustment continued through 2007. ■

Second Phase of the HIFA Evaluation Study

Project No: HHSM-500-2005-00027I/02
Project Officer: Paul Youket
Period: July 2006 to August 2008
Funding: $578,508
Principal Investigator: Bryan Dowd
Award: Task Order (MRAD)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: The contract was modified to authorize the exercise of Optional Task 2.3.2 at the estimated cost of $177,426. The contract is now fully funded.

Description: This task order will further evaluate the statistical significance and strength of the relationship between the Health Insurance Flexibility and Accountability (HIFA) initiative and the number and rate of uninsured for health care in states that implement HIFA demonstrations. ■

Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No: 95-P-09101/02
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Eli Feldman
Award: Waiver-Only Project
Awardee: Elderplan, Inc.
745 64th Street
Brooklyn, NY 11220

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The demonstration's payment methodology was based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend. In 2006 and 2007, the payment methodology changed to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that at the end of 2007 when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute-care service component.

Elderplan implemented its service delivery network in March 1985. Elderplan uses Medicare waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration, and 10 percent based on the new risk-adjustment system with the additional frailty adjustment. Elderplan enrollment at the end of 2005 was over 15,000 members. ■

Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research

Project No: 95-P-09103/00
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Lucy Nonnenkamp
Award: Waiver-Only Project
Awardee: Kaiser Permanente Center for Health Research
2701 NW Vaughn Street, Suite 160
Portland, OR 97210

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The demonstration's payment methodology was based on the CMS-HCC risk adjustment model using a 70/30 percent payment transition blend; but, in 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that at the end of 2007, when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services were provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate - two were health maintenance organizations (HMOs)

that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the HMO sites that developed and added a long-term care component to its service package.

Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II uses Medicare waivers only. The Balanced Budget Act (1997) extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act (1999) extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice Program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. Senior Advantage II enrollment at the end of 2005 was over 5000 members. ■

Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan

Project No: 95-P-09104/09
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Timothy C. Schwab
Award: Waiver-Only Project
Awardee: SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
P.O. Box 22616
Long Beach, CA 90801-5616

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The demonstration's payment methodology was based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend; but, in 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that at the end of 2007, when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component.

SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. SCAN Health Plan enrollment at the end of 2005 was over 76,000 members. ■

Solicitation Management and Provisions of Remote Panel Reviews

Project No: HHSM-500-2006-00054G
Project Officer: Ronald Hendler
Period: May 2006 to August 2008
Funding: $485,543
Principal Investigator: Lynn Leeks
Award: GSA Order
Awardee: LCG, Inc.
1515 Wilson Blvd
Rosslyn,VA 22209

Status: A modification was executed on this contract to extend the project period to a full two years through 8/24/2008. Also, additional grant solicitations were appropriated by Congress for FY 2007 that resulted in increasing the amount of the contract by $148,056 (date of modification 5/11/2007). The Contactor is completing the contract tasks on time, effectively and efficiently.

Description: The purpose of this task order is to provide complete grant application management and provision of remote grant panel reviews supporting the new Freedom Initiative and the Deficit Reduction Act of 2005 (DRA) Grant Programs. The contractor will manage the panel reviewer teleconferences for each panel. ■

State Health Insurance Assistance Program Data Collection and Performance Measurement System

Project No: 500-00-0032/12
Project Officer: Patricia Gongloff
Period: September 2004 to September 2007
Funding: $1,125,518
Principal Investigator: Yvonne Abel
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The contract has ended. It was modified in the past year to add $49,806 to the funding.

Description: The purpose of this project is to further refine the current SHIP reporting system and implement a performance measurement process. In addition, the contractor will generate SHIP performance reports based on data gathered for the most recent 6-month reporting periods. They will provide technical assistance to SHIP programs on their data reporting systems and analyze the SHIP Basic Grant distribution formula to determine whether it results in effectively funding the SHIP programs to meet the goal set forth in the enabling legislation.

Several tasks have been completed, including:

1. Developed design for enhanced performance measurement system.

2. Built enhanced performance measurement system - updated NPR forms to reflect MMA; and have begun full implementation of revised system for data submissions - Abt being initial point of review and communication with SHIPs.

3. Began training SHIPs on revised forms - led national training for all SHIP directors; now training local counselors.

4. Devised instruction manual for use of NPR forms.

5. Generated performance measurement reports for periods ending September 30, 2003; March 31, 2004; and September 30, 2004.

6. Posted reports on SHIP Web site.

7. Provided and continue to provide technical assistance to SHIPs; troubleshooting; telephone support; and training to SHIPs.

8. Coordinated with SHIP Resource Center on SHIP NPR training.

9. Worked with SHIP Performance Assessment Workgroup on revised NPR forms.

10. Provided project management through conference calls.

11. Has met with CMS staff at CMS twice to discuss projects.

12. Staffed HELP Desk at SHIP Annual Conference in Annapolis in May 2005.

13. Has begun collecting SHIP data for period ending March 31, 2005.

14. Has begun revisions to the cost savings algorithm.

15. Met with OIG staff on SHIP study they are conducting.

16. Worked with sub-contractor, Emagination, to revise the NPR forms and NPR Web site pages for July 1, 2005 launch.

17. Have begun to work with States to modify proprietary systems to comply with revisions to NPR forms and schedule of reporting.

18. Has provided technical assistance to 17 SHIPs that use state proprietary systems to upload data into the NPR website.

19. Identified data elements from the revised NPR forms that can potentially be used to identify benchmarks and performance targets for the SHIP network.

20. Worked with CMS to identify 9 data elements to be used for benchmarking and continues to work with CMS and its SHIP Performance Assessment Workgroup on this initiative.

21. Generated nationwide and State specific NPR (Client Contact, and Data Quality reports)for the quarterly reporting periods: April to March 2005 and July to September 2005 and is currently working on the reports for the period October 2005 to December 2005.

22. Created National Aggregate PAM report and produced PAM NPR reports for the period July 2005 to September 2005; and completed the Resource Report for the period April 2005 to September 2005.

23. Completed preliminary analysis of SHIP data and recommended performance targets for the proposed benchmarks; and recommended optons for how to apply benchmarks.

24. Provided data for a series of requests for data by CMS for use in the GAO Part D Communications report and the Region VII NPR report.

25. Completed face to face meetings with staff of selected SHIPs to discuss NPR data and data systems.

26. In conjunction with CMS, conducted a NPR teleconference training with the Oregon SHIP Director and its coordinators/counselors.

27. Held weekly conference calls with and worked with web master sub-contractor (Emagination)to trouble shoot and correct problems on the website related to NPR.

28. Provided feedback to Florida SHIP on its customer and counselor satisfaction surveys and toolkit that was developed under its CMS Competitive Leadership grant.

29. Met with Pennsylvania SHIP to discuss integration of SHIPtalk.org and SAMS data system in response to a request by the SHIP and an initiative under this Task Order to try to reduce duplication in reporting by some States. ■

Studies in Home Health Case Mix

Project No: 500-00-0032/03
Project Officer: Sharon Ventura
Ann Meadow
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 St.
Cambridge, MA 02138

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 included retesting interim results on the data available during Contract Year 2005 and assessment of model performance after accounting for outlier payments. The contract ended in December 2006.

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 Grouper and other types of technical assistance. All work will be conducted using existing administrative databases. ■

Studies of Use and Expenditure Patterns in Medicaid by Therapeutic Class of Drug for Selected Eligibility Groups

Project No: ORDI-IM-109
Project Officer: David Baugh
Gary Ciborowski
Period: August 2000 to December 2006
Funding: $0
Principal Investigator: Kathy Apodaka
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: During fiscal year 2001 the researchers added therapeutic classification data to each Medicaid prescription drug record. These data were acquired via a license from the data holder, First Data Bank of San Bruno, CA. During 2003 and 2004, the research team prepared three manuscripts using these data. All of these manuscripts have now been published. The references for these articles are:

• Baugh, D.; Pine, P.; Blackwell, S. and Ciborowski, G.: Central Nervous System Prescription Drug Use and Payments in Medicaid. Journal of Pharmaceutical Marketing and Management. 16 (2), pp. 63-82.

• Baugh, D.; Pine, P.; Blackwell, S. and Ciborowski, G.: Medicaid Prescription Drug Utilization and Payment in the 1990s: A Decade of Change. Health Care Financing Review. 26 (1), Fall 2004, pp. 57-73.

• Baugh, D.; Pine, P.; Blackwell, S. and Ciborowski, G.: Medicaid Spending and Utilization for Central Nervous System Drugs. Health Care Financing Review. 25 (3), Spring 2004, pp. 5-23.

• Baugh D.,Ciborowski,G.,and Blackwell, S.: Medicaid Prescription Drug

Spending and Utilization for Dual Enrollees. CMS Web Publication:

http://www.cms.hhs.gov/Reports/Reports/itemdetail.asp?filterType=dual,%20keyword&filterValue=Medicaid%20Prescription%20Drug%20Spending%20and%20Utilization%20for%20Dual%20Enrollees&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS1192490&intNumPerPage=10

Additional research is underway. The next article will examine Medicaid prescription drug utilization and spending for aged enrollees who received Beers drugs.

Description: This project uses Medicaid prescription drug data files to group drugs by therapeutic class for the years 1994 through 2002. A series of intramural studies is planned. Research questions to be addressed include:

(1) What types of drugs are used by Medicaid eligibility groups?

(2) What are the program payments for drugs by Medicaid Program and enrollee characteristics?

(3) What are the characteristics of settings where drugs are prescribed and how are they changing?

(4) What are the utilization and program payments for high cost drugs?

(5) What are the causes for Medicaid drug payment increases?

(6) What can we learn about drug utilization patterns in fee-for-service to identify any access and under-utilization problems after the implementation of prepaid plans?

(7) What are the trends in drug utilization, by therapeutic category of drugs?

(8) What are the levels of utilization and program payment for off-labeled uses of drugs?

(9) What are the benefits-versus-cost tradeoffs of prescribing later-generation as opposed to earlier-generation drugs? ■

Study of Paid Feeding Assistant Programs

Project No: 500-00-0049/02
Project Officer: Susan Joslin
Period: September 2004 to September 2008
Funding: $597,374
Principal Investigator: Terry Moore
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Phase II has been extended to September 30, 2008.

Phase I was completed in September 2007. The final report for the Phase I project is available at:http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=dual,%20keyword&filterValue=paid%20feeding%20assistant&filterByDID=0&sortByDID=4&sortOrder=ascending&itemID=CMS1203286&intNumPerPage=10

Description: The purpose of this Phase II Study of Paid Feeding Assistants is to design, implement and evaluate an optimal feeding assistant program, one that is not only consistent with federal requirements for paid feeding assistant (PFA) training but that provides more hands-on guidance for both supervisory and feeding assistant staff about how to enhance the quality of both the dining experience and the nutritional intake of the nursing home resident. ■

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

Project No: HHSM-500-2006-00006I/08
Project Officer: Steve Blackwell
Period: August 2007 to August 2009
Funding: $431,469
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: A contract was awarded to Acumen in September 2007 to conduct this research. The project is currently on hold pending the availability of prescription drug event data for research purposes.

Description: This Task Order will further study 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. 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. However, the Secretary recommended, given the complexity of the issues, that further analyses would be necessary once Medicare had at least two years of experience with the new prescription drug program. This study aims to better understand the financial and programmatic impacts of consolidating certain categories of similar drugs under one program. ■

Sustaining Culture Change in LTC Facilities for the Elderly

Project No: 18-P-91857/03-02
Project Officer: Mary Clarkson
Period: September 2003 to September 2007
Funding: $297,350
Principal Investigator: Cheryl Cooper
Award: Grant
Awardee: Jefferson Area Board for Aging
674 Hillsdale Ave., Suite 9
Charlottesville, VA 22901

Status: This grant was awarded for Fiscal Years 2003, 2004, and 2005.

Description: This grant continues work started under prior year Congressional funding. The current project has been designed to identify, demonstrate, and widely disburse interventions for long term care facilities (nursing homes and assisted living facilities) that are designed to improve the well-being of residents, staff, administrators, family members, and involved public. These interventions include the following: measurement tools, training tools for staff, an "embracing elderhood" intergenerational program, and research on risks involved with these interventions in long term care with consideration of how to balance risk with quality of life and well-being. ■

Sustaining the Access Health "Three-Share" Model of Community Health Coverage: Marketing the Product and Managing the Risk

Project No: 18-C-92395/05-01
Project Officer: Carl Taylor
Period: August 2004 to January 2007
Funding: $948,200
Principal Investigator: Peter Sartorius
Award: Grant
Awardee: Muskegon Community Health Project
565 West Western Ave
Muskegon, MI 49440

Status: This project has now been completed.

Description: This was a continuation grant that built on earlier (2004) research that contributed a project design and evaluation. The purpose of Access Health was to provide an affordable health coverage product to a niche of small businesses and their employees who were able to assist in payment of coverage, but unable to participate at commercial levels. Funding came from three sources: employer, employee, and community. Thus, the funding structure was a Three-Share model. The goal of the project was to continue to reduce the number of uninsured people in Muskegon County. ■

System and Impact Research and Technical Assistance for CMS Fiscal Year 2005 Real Choice Systems Change Grants

Project No: 500-00-0049/03
Project Officer: Cathy Cope
Period: September 2005 to September 2011
Funding: $4,197,421
Principal Investigator: Yvonne Abel
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Summaries of susequent year grants have been completed and are on the CMS website. The Strategic Plan Template and initial onsite visits for the Systems Transformation (ST) Grantees have been completed. All Tasks and activities on are time. Finalization of Strategic Plan web format and review and approval of ST Grantees Strategic Plans are completed. The web-based RCSC Grant Program management reports are in development.

The contract was recently modified to: (1) increase the level of effort for Task 7,(2) modify Task 4 and (3) revise the Statement of Work and the Schedule of Deliverables.

Description: The purpose of this task order is to: examine the systems and impacts of the Fiscal Year 2005 Real Choice Systems Change (RCSC) Grants; provide limited technical assistance (TA) to Centers for Medicare and Medicaid Services (CMS) regarding strategic planning and grants management; and provide limited TA to FY05 RCSC Grantees regarding strategic planning, evaluation strategies and outcome measurement. The information from this work will be used to inform interested partners within the Department of Health and Human Services, congressional sponsors, all Systems Change Grantees, and Federal and State decision-makers. This task order will run for the duration of the FY05 RCSC Grants in order to capture the activities and outcomes of the specific grants being evaluated under this task order. ■

Technical Assistance Resource Center for Direct Service Workforce Development

Project No: 500-00-0051/06
Project Officer: Kathryn King
Period: September 2005 to September 2008
Funding: $1,759,532
Principal Investigator: Lisa Maria Alecxih
Award: Task Order (RADSTO)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: The Lewin Group developed the infrastructure for the Resource Center including a website, email address, and phone number to respond to basic TA questions from all sources. In addition, Lewin assisted CMS in developing a competitive process to select 5 State Medicaid agencies for Intensive TA (Texas, South Carolina, New York, Louisiana, Arizona) and is now delivering extensive TA to these States. The contractor has also developed a "Funding Sources Report" and mechanisms for peer-to-peer learning. The contract was recently modified to increase the scope of work for the subcontractor.

Description: The purpose of this task order is to provide funding to create a National Program Office (NPO), or Resource Center, for direct service worker initiatives. The NPO contractor will provide programmatic technical assistance to State and local governments, not-for-profit organizations and the Centers for Medicare and Medicaid Services (CMS) for the purpose of recruitment, training, and retention of direct service workers (DSWs) for persons with disabilities and elderly individuals with long term illnesses. ■

Techniques Taken by States To Rebalance Their Long Term Care System

Project No: 500-00-0053/03
Project Officer: Kathryn King
Period: September 2004 to March 2008
Funding: $2,111,440
Principal Investigator: Linda Clark-Helms
Rosalie Kane
Robert Kane
Award: Task Order (RADSTO)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: Annual reports of the contract are available on the NFI Web site. They include an executive summary of findings from the past year as well as an in-depth case study and highlight report for each of the 8 States. A NFI Open Door Forum was held in the early stages of the project to get suggestions for the targeted papers of study. Topics were choosen for research papers and Data analysis linking Max data with States' finder files was made. A lot of interesting findings have been made at this point.

Description: The Centers for Medicare & Medicaid Services (CMS) will, through a Contractor, work with three to eight States who are in the process of rebalancing and research the program management techniques used by these States to provide adequate services while effectively managing aggregate costs. CMS will also, through a Contractor, work with these States to gather and report on the changes in aggregate costs and per person expenditures to the Medicaid program and the numbers of individuals receiving institutional and community-based care. ■

TennCare II

Project No: 11-W-00151/04
Project Officer: Kelly Heilman
Period: May 2002 to June 2010
Funding: $0
Principal Investigator: Darin Gordon
Award: Waiver-Only Project
Awardee: Tennessee, Department of Finance and Administration, TennCare Bureau
729 Church Street
Nashville, TN 7247-6501

Status: On October 5, 2007, a three-year extension was approved, through June 30, 2010. The State has nearly completed disenrollment of adult Demonstration eligibles. Transition of persons enrolled in the closed Medically Needy group into the new Medically Needy Demonstration group is expected to begin within one month of the extension date.

Description: TennCare II, implemented July 1, 2002, took the place of the original TennCare Demonstration (11-W-0002/04), which ended on July 30, 2002. Like its predecessor, the TennCare II Demonstration uses savings from mandatory Medicaid managed care and reallocation of Disproportionate Share Hospital funds to extend Medicaid eligibility to selected low-income uninsured populations. All Medicaid State Plan eligibles are enrolled in managed care under TennCare II, except those whose only Medicaid benefits consist of Medicare premium payments. State Plan populations receive the TennCare Medicaid benefit package, while expansion population receive TennCare Standard, with some State Plan benefits omitted. Since 2005, significant changes have been made to the list of covered populations. Coverage has been discontinued for Demonstration eligible uninsured adults, and the State plan non-pregnant medically needy adults group was closed to new enrollment. In November 2006, a waiver amendment was approved to cover non-pregnant medically needy adults as a Demonstration population, with enrollment capped at 105,000. ■

Tennessee Families First Demonstration

Project No: 11-W-00104/04
Project Officer: Not Available
Paul Youket
Period: September 1996 to June 2007
Funding: $0
Principal Investigator: David Goetz
Award: Waiver-Only Project
Awardee: Tennessee, Department of Human Services
400 Deaderick Street
Nashville, TN 37248

Status: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 permitted States to continue many of the policies that had previously required waivers of pre-welfare reform by submitting a Temporary Assistance for Needy Families plan to the Administration for Children and Families. Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstrations. No further information on the status of this project has been received by CMS.

Description: Families First is a Welfare Demonstration. CMS approved waivers of the specific Medicaid regulations to provide 18 months of transitional Medicaid to people regardless of the reason for Aid to Families and Dependent Children (AFDC) case closure and/or whether the person was on AFDC for 3 out of the preceding 6 months. ■

Ticket to Work Initiatives

Project No: 500-00-0047/05
Project Officer: Stephen Hrybyk
Period: May 2006 to May 2008
Funding: $1,853,273
Principal Investigator: Dr. Su Lui
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contract was modified to exercise Optional Phase 2 and Optional Phase 3 and the period of performance was extended to May of 2008.

Description: The purpose of this project is to evaluate the effectiveness of three initiatives contained in the Ticket to Work and Work Incentives Improvement Act of 1999. Section 201 of the Act expanded the eligibility for Medicaid to workers with disabilities (Medicaid Buy-In or MBI), and Section 204 provided for a demonstration to provide health care benefits to workers with potentially disabling conditions (Demonstration to Maintain Independence and Employment). In conjunction with Section 201, Section 203 provides grants to States to establish infrastructures that support working individuals with disabilities. These efforts require that CMS focus on two types of outcomes: employment and health status. The Medicaid Infrastructure Grant (MIG) program requires that CMS, in consultation with the Ticket to Work and Work Incentives Advisory Panel, report on the effectivness of the MIG program and whether it should be continued. The Demonstration to Maintain Independence and Employment (DMIE) required that each state grantee do an independent evaluation. This project will provide a coherent national analysis of the MBI and DMIE efforts. The research files, thus created, will provide for a longitudinal analysis of the MBI and DMIE efforts. ■

Time Study Project Data Collection and Analysis

Project No: 500-02-0030/02
Project Officer: Kathryn Jansak
Jeanette Kranacs
Period: September 2005 to July 2009
Funding: $6,055,662
Award: Task Order
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway
West Des Moines, IA 50266

Status: The contractor has established a technical expert panel, recommended clinical design, recruited State agencies, conducted two pilot time studies, and completed the on-site time and data collection. The contractor and subcontractors are now beginning work on the second phase: data analysis that will evaluate the RUG-III grouper methodology and recalibrate the case mix weights.

Description: This Task Order shall implement and manage CMS' multistate nursing home time study (also known as Staff Time and Resource Intensity Verification (STRIVE)) including the following tasks: establishing a technical expert panel; recruiting nursing homes, State agencies, and volunteers to participate; providing hardware, software, and training to obtain the data in a useable form; coordinating the data collection in a pilot test; and conducting the time study. In the second phase, the contractor shall analyze the data obtained, reevaluate the RUG-III grouper methodology, and recalibrate the case mix weights. ■

Trends in Enrollee Characteristics in the Medicare Risk Contracting Program

Project No: ORDI-IM-2006-00001
Project Officer: Gerald Riley
Period: October 2005 to October 2006
Funding: $0
Principal Investigator: Gerald Riley
Carlos Zarabozo
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: Study findings were published in the Winter 2006/2007 issue of the *Health Care Financing Review*. The abstract of the article is listed below.

Abstract

Previous research has found Medicare risk contract enrollees to be healthier than beneficiaries in fee-for-service (FFS). Medicare Current Beneficiary Survey data were used to examine trends in health and functional status measures among risk contract and FFS enrollees from 1991 to 2004. Risk contract enrollees reported better health and functioning, but the differences tended to narrow over time. Most of the differences in trends were observed for functional status measures and institutionalization; differences in trends for perceived health status and prevalence rates of chronic conditions tended to be small or non-existent. The narrowing of functional and health status differences between the risk contract and FFS populations may have implications for payment policy, as well as implications for the role of private health plans in Medicare.

Riley G, Zarabozo C. Trends in the health status of Medicare risk contract enrollees. Health Care Financing Review. Vol. 28, No. 2 pp. 81-95. Winter 2006/2007.

Description: Previous research has found Medicare risk contract enrollees to be younger and healthier than beneficiaries in fee-for-service (FFS). Medicare Current Beneficiary Survey data from the Access to Care files were used to examine trends in demographic, health, and functional status measures among risk contract and FFS enrollees from 1991 to 2004. ■

Trends in Out-of-Pocket Health Care Costs for Community Dwelling Medicare Beneficiaries

Project No: CMS-06-110106
Project Officer: Gerald Riley
Period: November 2006 to April 2008
Funding: $0
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: A draft paper is currently under review.

Description: Many Medicare reform proposals call for more beneficiary contributions to the cost of their health care. This study examines recent trends in beneficiary out-of-pocket health care costs, using data from the Medicare Current Beneficiary Survey (MCBS) Cost and Use Files for 1992-2004. The study is limited to the community dwelling population. All out-of-pocket health care costs are included, and not just those associated with Medicare-covered services, in order to get a complete picture of the financial burden of health care on beneficiaries. Several questions are addressed: 1) How much have out-of-pocket costs increased in relation to total health care costs and to income? 2) Has the distribution of out-of-pocket costs changed over time? 3) Have the major components of out-of-pocket costs changed and are they different for the highest cost beneficiaries? 4) How do costs vary by type of supplemental insurance? 5) To what extent do high out-of-pocket costs persist from year to year? ■

United Mine Workers of America Demonstration: An Integrated Care Coordination/Management Program for an Elderly, Chronically-Ill Population

Project No: 95-C-99643/03
Project Officer: Jason Petroski
Period: July 1990 to September 2007
Funding: $0
Principal Investigator: Joel Kavet
Award: Demonstration
Awardee: United Mine Workers of America Health and Retirement Funds
2121 K Street, NW
Washington, DC 20037

Status: This demonstration project ended on September 30, 2007.

Description: The United Mine Workers of America Health and Retirement Funds (UMWA /the Funds) has been a Health Care Prepayment Plan (HCPP) since 1978. It acts as a Medicare carrier; that is, carriers have instructions to forward all Part B claims they receive for the Funds beneficiaries to the Funds for processing. The Part A claims incurred by the Funds beneficiaries are paid by CMS's Fiscal Intermediary.

In 1990, the Centers for Medicare and Medicaid Services (CMS) (at the time referred to as HCFA) initially approved a demonstration to pay Part B services on a capitated basis rather than on a cost basis. In 1997, CMS approved waivers that continued the Part B capitation approach and included risk sharing for Part A services.

The basic risk-sharing methodology involves setting an experience-based Part A expenditure target prior to each payment year. After each payment year there is a reconciliation, whereby the actual Part A expenditures for the Funds beneficiaries are compared to the target. Any savings or losses are shared equally (50/50) between CMS and UMWA once a 2-percent bracket is exceeded around the target. The Funds gains and losses are capped between 88-112 percent of the target. Each year's target amount is determined from a rolling 3-year old base trended forward using Medicare inflation rates.

In order to improve the management and coordination of care for its elderly population, the Funds has implemented various programs/services (many of which are found in managed care type plans). The majority of these programs/services are focused in three "target" areas; where the Funds have established relationships with local providers. Despite the appearance of a managed care type delivery system in these parts of Alabama, Pennsylvania and West Virginia, the provision of health care primarily remains on a fee-for-service basis. The Funds Medicare beneficiaries reside in almost every State and, as a result of statutory obligations placed on the Funds, (in most cases) have freedom of choice in choosing their health provider and/or supplier.

One of the Funds strategies is to substitute less expensive care whenever appropriate. The Funds continues to encourage primary and preventive care among its population in lieu of more expensive hospital care. Most of the interventions are designed to manage care provided in a fee-for-service setting, which include: disease management, pre-certification of selected services, implementation of a pilot telephonic nurse advice line, coordination of care, networks of primary care providers that are designed to function in an open-access environment, and a state of the art prescription drug management program which is currently provided by Caremark, Inc., a pharmacy benefit manager (PBM).

In 2001, CMS began paying a percentage of the Funds prescription benefit drug cost (up to 27 percent of the Funds net prescription drug expenditures). This percentage was increased to greater than 65 percent in 2004, as per the 2005 Presidential budget. CMS obtains information on the management of the prescription benefit, including using a pharmacy benefit manager, mandatory generic substitution, use of preferred pharmacy products, utilization review, and other techniques.

In September 2005, CMS again extended the demonstration. This award continues CMS support for Part A and B services, and prescription drugs, from October 1, 2005 through September 30, 2007. Included as part of this extension is a timeline for transitioning the demonstration to non-demonstration status and a requirement for the Funds to complete a related feasibility study looking at non-demonstration alternatives. This extension also included a significant change with respect to how the prescription drug support is financed. For each fiscal year, the Funds will receive reimbursement for up to 66% of its net drug expenditures through two payment sources. Part of the funding will come from the Funds successful application to the Retiree Drug Subsidy program and the additional amounts will be paid using demonstration waiver authority. ■

Utah Primary Care Network

Project No: 11-W-00145/08
Project Officer: Kelly Heilman
Period: February 2002 to June 2010
Funding: $0
Principal Investigator: David Sandwall
Award: Waiver-Only Project
Awardee: Utah, Department of Health
288 N. 1460 West, 3rd Floor, P.O. Box 143108
Salt Lake City, UT 84114-3108

Status: On December 21, 2006, the Demonstration was approved for a three-year extension.

Description: Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage through increased flexibility with certain able-bodied State plan eligibles who are categorically or medically needy parents or other

caretaker relatives. For these State plan populations, the Demonstration provides a reduced benefits package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 and older with incomes up to 150% FPL. This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also, high risk pregnant women, whose resources made them ineligible under the State plan, are covered under the Demonstration for the full Medicaid benefits package. The PCN Demonstration was amended in October 2006 to offer assistance with payment of premiums for employer-sponsored health insurance (ESI) for up to 1,000 uninsured, low-income (up to 150 percent FPL) working adults and up to 250 SCHIP-eligible children of such adults. ■

Waiver Management System Database and Grant On-Line Management System

Project No: 500-00-0021/04
Project Officer: Herbert Thomas
Period: August 2005 to August 2008
Funding: $4,079,117
Principal Investigator: Majorie Hatzman
Award: Task Order (RADSTO)
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: The latest modification added Matrix Consulting, LLC as a subcontractor and added a consultant.

Description: The purpose of this Task Order is to collect accurate data, and analyze it in a timely manner. The Waiver Management System database (WMSD) and the Grant On-Line Management System to be developed and implemented under this Task Order are designed to fulfill this need. ■

Wisconsin Partnership Program (WPP)

Project No: 11-W-00123/05
Project Officer: James Hawthorne
Period: October 1998 to December 2006
Funding: $0
Principal Investigator: Cecilia Chathas
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
One West Wilson Street, PO Box 309
Madison, WI 53701

Status: The WPP plans were approved as institutional Special Needs Programs (SNPs) effective January 1, 2006 and were reclassified as dual-eligible SNPs with Medicaid subsets effective January 1, 2008. With the exception of a payment waiver, they have been operating under regular Medicare Advantage since January 1, 2007. The payment waiver will be phased out as of January 1, 2011. The demonstration's Medicare 402/222 and Medicaid 1115 waivers expired December 31, 2007. As of January 1, 2008, the program will operate a State plan amendment under 1932(a) and two new 1915(c) Medicaid waivers (one for the disabled and elderly population and the other for persons with developmental disabilities).

Description: The State of Wisconsin submitted an application to the Centers for Medicare and Medicaid Services (then HCFA) in February 1996 for Medicare 402/222 and Medicaid 1115 demonstration waivers to establish a "Partnership" model of care for dually-entitled nursing home-certifiable beneficiaries who are either elderly or under age 65 with physical disabilities. Waivers were approved for this demonstration on October 16, 1998 and all four sites called for in the demonstration–Elder Care and Community Living Alliance (CLA) in Madison, Community Care for the Elderly (CCE) in Milwaukee, and Community Health Partnership (CHP) in Eau Claire–became operational between January 1, 1999 and May 1, 1999. A total of 2,200 beneficiaries were enrolled as of September 30, 2007. In Milwaukee, the Partnership site is co-located with a pre-existing PACE (Program of All-inclusive Care for the Elderly) site and serves an elderly population. ElderCare also serves only elderly participants. CLA serves only people under 65 with disabilities and CHP serves both populations. The CLA and CHP were the first plans in the nation to provide fully capitated Medicare and Medicaid services for people with physical disabilities. Roughly a quarter of Partnership enrollees are persons with disabilities and about 85% of

the total enrollment is dually eligible. The proportion of dual eligibles varies from 60% among persons with disabilities to 95% among the elderly.

The Partnership model is similar to the PACE model in the use of multidisciplinary care teams, combined Medicare and Medicaid capitation payments, and sponsorship by community-based service providers. The programs differ in two important ways. The Partnership treatment team consists of a community-based primary care physician (PCP) plus a nurse practitioner, nurse, and social worker that are employed by the health plan. The plan-based team members provide in-home services and facilitate continuity and coordination of care with the PCP and other health providers. The Partnership team is smaller than the PACE team since it does not include occupational, physical, or speech therapists. Partnership plans also do not require direct participation of primary care physicians in team meetings as does PACE. In the Partnership model, the nurse practitioner has primary responsibility for coordinating the activities of the plan-based team with those of the community-based physician. A second important difference between the two programs is that PACE sites have traditionally established day treatment programs where participants receive their primary care along with a variety of therapies and supportive services.

While most participants in the Partnership program are able to choose their PCP, there is not complete freedom of choice because plans must place some limits on the number of participating physicians in order to maintain efficient communication and coordination between the plan-based team members and the community-based physicians. Plans have also found that physicians are more likely to "buy into" the Partnership model when more of their patients are program participants.

An evaluation of the Partnership Program was done by an independent CMS contractor and the findings are available at http://www.cms.hhs.gov/reports/downloads/Kane2_2004_1.pdf. Overall, there were relatively few differences in utilization between the WPP and the two control groups. Comparisons with PACE were limited to three analyses, two of hospital and one of ER utilization. PACE had slightly lower admission rates but the two programs did not differ in terms of total hospital days. ER admissions were lower for PACE but the difference, while statistically significant, was too small to have practical significance. The findings in regard to preventive services were mixed, with the WPP providing more of some services and fewer of others relative to the comparison groups. There was a moderate tendency for WPP participants to receive more lab and x-ray services. WPP enrollees tended to have fewer preventable hospital admissions than the control groups and there was a modest trend involving lower mortality for disabled WPP enrollees.

More information on the Wisconsin Partnership Program is available on the internet at: http://www.dhfs.state.wi.us/WIpartnership/. ■

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U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Research, Development, and Information
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Baltimore, Maryland 21244-1850