2011 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 CHIP. The Active Projects Report provides a brief description of each project and its status. It also provides an identification 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-ninth edition of the Active Projects Report. For more information, please visit the CMS Web site at http://www.cms.hhs.gov/ActiveProjectReports.

Acute Care Episode Demo Beneficiary Shared Savings (ACE)

Project No: HHSM-500-2008-00014I/HHSM-500-T0002
Project Officer: Wayne Slaughter
Cynthia Mason
Period: June 2009 to June 2012
Funding: $473,290.00
Principal Investigator: Nazar Mohl
Award: Task Order
Awardee: TFS Group, Inc.
2141 Industrial Parkway
Silver Spring, MD 20904

Status: The project commenced in June 2009 and is midway through the second year of its three year project time frame. Payments have been distributed to beneficiaries on a monthly basis as required by the SOW.

Description: This task order will define a methodology for making a shared savings payment to those Medicare beneficiaries who: (1) have elected to receive specifically identified inpatient care at the demonstration sites; (2) for processing beneficiary payments and IRS 1099 forms; and (3) for producing records of beneficiary payments for CMS. ■

Acute Care Episode Demonstration - Hillcrest Medical Center – Oklahoma

Project No: 95-W-00257/06
Project Officer: Cynthia Mason
Period: May 2009 to April 2012
Funding: $ 0.00
Principal Investigator: Steve Dobbs
Award: Waiver-Only Project
Awardee: Hillcrest Medical Center
1120 South Utica Avenue
Tulsa, OK 74104

Status: Hillcrest Medical Center in Tulsa, Oklahoma implemented the three year demonstration for both cardiovascular and orthopedic procedures on May 1, 2009.

Description: This three year demonstration tests the effect of bundling Medicare Part A and Part B payments for acute episodes of care to improve the coordination, quality, and efficiency of that care. Five sites in a four-state area were selected as Value-Based Care Centers for designated cardiovascular and/or orthopedic procedures. ■

Acute Care Episode Demonstration – Baptist Health System - Texas

Project No: 95-W-00254/06
Project Officer: Cynthia Mason
Period: June 2009 to May 2012
Funding: $ 0.00
Principal Investigator: Harold Pilgrim III
Award: Waiver-Only Project
Awardee: Baptist Health System
111 Dallas Street
San Antonio, TX 78205

Status: Baptist Health System in San Antonio, Texas implemented the demonstration for both cardiovascular and orthopedic procedures on June 1, 2009.

Description: This three year demonstration tests the effect of bundling Medicare Part A and Part B payments for acute episodes of care to improve the coordination, quality, and efficiency of that care. Five sites in a four-state area were selected as Value-Based Care Centers for designated cardiovascular and/or orthopedic procedures. ■

Acute Care Episode Demonstration – Exempla Saint Joseph Hospital - Colorado

Project No: 95-W-00255/08
Project Officer: Cynthia Mason
Period: November 2010 to October 2013
Funding: $ 0.00
Principal Investigator: Jessica Jarnot
Award: Waiver-Only Project
Awardee: Exempla Saint Joseph Hospital
1835 Franklin Street
Denver, CO 80218

Status: Exempla Saint Joseph Hospital in Denver, Colorado implemented the demonstration for cardiovascular procedures on November 1, 2010.

Description: This three year demonstration tests the effect of bundling Medicare Part A and Part B payments for acute episodes of care to improve the coordination, quality, and efficiency of that care. Five sites in a four-state area were selected as Value-Based Care Centers for designated cardiovascular and/or orthopedic procedures. ■

Acute Care Episode Demonstration – Lovelace Health System - New Mexico

Project No: 95-W-00256/06
Project Officer: Cynthia Mason
Period: November 2010 to October 2013
Funding: $ 0.00
Principal Investigator: Ron Stern
Award: Waiver-Only Project
Awardee: Lovelace Health System
4101 Indian School Road, Suite 405
Albuquerque, NM 87110

Status: Lovelace Health System in Albuquerque, New Mexico implemented the demonstration for orthopedic procedures on November 1, 2010.

Description: This three year demonstration tests the effect of bundling Medicare Part A and Part B payments for acute episodes of care to improve the coordination, quality, and efficiency of that care. Five sites in a four-state area were selected as Value-Based Care Centers for designated cardiovascular and/or orthopedic procedures. ■

Acute Care Episode Demonstration – Oklahoma Heart Hospital - Oklahoma

Project No: 95-W-00258/06
Project Officer: Cynthia Mason
Period: January 2010 to December 2012
Funding: $ 0.00
Principal Investigator: John Harvey
Award: Waiver-Only Project
Awardee: Oklahoma Heart Hospital
4050 West Memorial Road
Oklahoma City, OK 73120

Status: Oklahoma Heart Hospital in Oklahoma City, Oklahoma implemented the demonstration for cardiovascular procedures on January 1, 2010.

Description: This three year demonstration tests the effect of bundling Medicare Part A and Part B payments for acute episodes of care to improve the coordination, quality, and efficiency of that care. Five sites in a four-state area were selected as Value-Based Care Centers for designated cardiovascular and/or orthopedic procedures. ■

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 2010
Funding: $299,780.00
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: This Project ended as scheduled on September 30, 2010. Two final papers were produced, as follows:

1. "Event Analysis of All-Cause and Ambulatory Care Sensitive Hospitalization of Long-Stay Nursing Home Residents" can be found online at http://www.cms.gov/Reports/Downloads/Bishop_NHAdverseEventsChronIllness_Final_2010.pdf

2. "Time to Readmission among Chronically Ill Community-Resident Beneficiaries: Variations by Geographic Area and Provider Type" can be found online at http://www.cms.gov/Reports/Downloads/Perloff_CommDwellers_AdverseEventsChronIllness_2010.pdf

Description: This task order conducted analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. This task order was extended to September 30, 2010. ■

Agreed Upon Procedures Review of XLHealth's Operational Procedures and Expenditures Relating to the Benefits Improvement and Protection Act (BIPA) Disease Management Demonstration

Project No: GS-23F-0135L/HHSM-500-2006-00018G
Project Officer: Juliana Tiongson
Period: February 2006 to January 2010
Funding: $275,127.00
Principal Investigator: William Oliver
Award: GSA Order
Awardee: Clifton Gunderson
4041 Powder Mill RoadSuite 410
Calverton, MD 20705

Status: This project ended on January 31, 2010.

Description: This task order performed 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. ■

Alabama Family Planning ("Plan First")

Project No: 11-W-00133/04
Project Officer: Juliana Sharp
Period: June 2000 to September 2011
Funding: $ 0.00
Principal Investigator: Carol Hermann-Steckel
Award: Waiver-Only Project
Awardee: Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36103-5624

Status: On February 19, 2010, CMS approved an amendment for the Demonstration to add the procedure code for an ultrasound procedure related to Implanon insertion to the list of approved procedure codes. The Demonstration is set to expire on September 30, 2011. As of September 30, 2010, 82,309 individuals were enrolled in the Demonstration.

Description: This demonstration provides coverage for family planning services for uninsured women ages 19

through 44 who are not otherwise eligible for Medicaid or other coverage that provides family planning services, and who have family income at or below 133% FPL. ■

Alternative Approaches to Measuring Physician Resource Use

Project No: HHSM-500-2005-00027I/0004
Project Officer: Craig Caplan
Period: September 2008 to May 2011
Funding: $1,499,979.00
Principal Investigator: David Knutson
Award: Task Order (RADSTO)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: The contractor is conducting analyses of episode-based and per capita approaches. The project's second interim report that summarizes work to date is near completion. A no-cost contract modification is in the process of being drafted that would extend the end date until April 28, 2012.

Description: CMS and others in the policy community have been increasingly interested in moving to a value based purchasing (VBP) system for physicians under original fee-for-service Medicare. Under VBP, physicians' payments would depend on the "value" of services provided. Physicians who routinely use relatively few resources while maintaining adequate quality services would receive larger payment updates than physicians providing similar or lower quality services with more resources. CMS has focused on the use of commercially developed episode groupers to measure resource use, but few studies have examined feasible options in Medicare. The purpose of this task order is to develop and analyze alternative approaches to measuring physician resource use. ■

Analysis of Transportation Barriers to Utilization of Medicare Services by American Indian and Alaska Native (AI/AN) Medicare Beneficiaries

Project No: GS-00F-0012S/HHSM-500-2009-00097G
Project Officer: Rodger Goodacre
Period: September 2009 to September 2010
Funding: $447,999.00
Principal Investigator: Michael Myer
Award: GSA Order
Awardee: Kauffman and Associates, Inc.
South 165 Howard Suite 200
Spokane, WA 99201

Status: The project has concluded.

Description: The purpose of this task order was to design a protocol and instrument to perform the analysis of transportation barriers to utilization of Medicare services by American Indian and Alaska Native (AI/AN) beneficiaries. Subsequently, the protocol and instrument would be implemented in remote locations to collect data on the impact of transportation on Medicare beneficiaries' behavior in utilizing non-emergency services. The goal behind this research project is to provide baseline data on the access to and quality of health care for AI/AN Medicare beneficiaries residing in tribal communities, as a consequence of transportation. Tribal Affairs Group (TAG) anticipates such knowledge will be of great value to policy makers, CMS, IHS, tribes, and states; and will also provide information that may be of value to other rural and isolated communities and populations. As both health disparities and health care reform are increasingly topics of national interest, assessing the impact of transportation related barriers to access for health care services may be a critical component in those discussions and policy decisions. Proposals for research will be assessed according to the extent that results will realistically approach the goal. ■

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

Project No: HHSM-500-2006-00048C
Project Officer: William Cymer
Period: September 2006 to September 2011
Funding: $2,938,099.00
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 years one, two, three, and four have been exercised.

Description: This contract, with an exercised option to extend the period of performance through a fourth option year ending September 24, 2011, allows the Kidney Epidemiology and Cost Center (KECC), through the Regents of the University of Michigan, to continue research which will inform the development of policy options for expansion of and potential modifications to the end stage renal disease prospective payment system (ESRD PPS). The ESRD PPS was implemented effective January 1, 2011 as a result of the July 15, 2008 enactment of Pub. L. 110-275, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 153(b) of MIPPA amended section 1881(b) of the Social Security Act to require the implementation of a bundled ESRD PPS effective that date. The bundled ESRD PPS covers renal dialysis services furnished by outpatient ESRD facilities, and combines the routine maintenance dialysis services reimbursed under the composite payment system with previously separately billable services into a single payment rate, adjusted for patient-specific differences in case-mix. KECC's research will build upon, extend, and update previously completed research in accordance with the provisions of CMS's final rule implementing the ESRD PPS, published in the August 12, 2010 Federal Register at 75 FR 49030. KECC's research is designed to assist CMS in fulfilling MIPPA's mandatory and discretionary objectives. ■

Application of Episode Groupers to Medicare

Project No: HHSM-500-2006-00006I/0005
Project Officer: Fred Thomas
Period: August 2007 to October 2013
Funding: $444,398.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: Work has included an analysis of the functionality of the two episode groupers, a prototype profiling system and associated issues, and other analysis that involves episode grouping. The following reports have been completed: Evaluating the Stability of Physician Efficiency Scores (2010), Evaluating the functionality of the Symmetry Episode Treatment Groups (ETG) and the Thomson Medstat Medical Episode Grouper (MEG) software in forming episodes of care using Medicare data (2008) (http://www.cms.hhs.gov/Reports/downloads/MaCurdy.pdf), Challenges in the risk adjustment of episode costs (2010), and Prototype Medicare resource utilization report based on episode groupers (2008) (http://www.cms.hhs.gov/reports/downloads/MaCurdy2.pdf).

Description: Since 2006, CMS has been investigating techniques that can help identify higher cost practice patterns. One technique is to compare resource use at the episode of care level. Episodes of care represent a group of healthcare services (claims) for a health condition (e.g., hip fracture, diabetes) over a defined length of time for which a physician can be responsible. Episode groupers are software programs that organize claims data into a set of clinically coherent episodes, usually linked by diagnosis. Episode grouping software requires users to specify the input parameters for a given set of outputs. Acumen adapted Medicare claims (Parts A and B, and no Part D) for grouping, developed a framework to compare episodes generated by each grouper on a common set of claims data, and assessed the impact of the numerous grouping options and profile settings available in each grouper. Using a 20% sample of 2003 Colorado data, Acumen grouped about 5 million Medicare claims using the January 2008 versions of Symmetry Episode Treatment Groups (ETG) and the Thomson Medstat Medical Episode Grouper (MEG) software. Approximately 660,000 episodes resulted from this grouping process using either grouper software. ■

Arbitration Services for the home Health Third Party Liability Demonstration

Project No: HHSM-500-2010-00068C
Project Officer: Diane Ross
Period: September 2010 to September 2011
Funding: $528,000.00
Principal Investigator: Pierre Paret
Award: Contract
Awardee: American Arbitration Association
601 Pennsylvania Avenue, NW
Washington, DC 20004-2676

Status: The project is underway.

Description: The purpose of this contract is to procure arbitration services to resolve disputes with three States concerning Medicare coverage of certain home health services furnished to dual eligible beneficiaries and paid by the States' Medicaid programs. ■

Arizona Health Care Cost Containment System

Project No: 11-W-00032/09 and 21-W-00009/09
Project Officer: Jessica Schubel
Period: July 1982 to September 2011
Funding: $ 0.00
Principal Investigator: Thomas Betlach
Award: Waiver-Only Project
Awardee: Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Status: Several requests to amend the Demonstration are pending with CMS. The State has proposed to add Community Transition Services to the Home and Community-Based Services package offered under ALTCS, to update the disproportionate share hospital protocol, and to update the service package definition for Demonstration populations to mirror changes to the Medicaid State Plan. The State also has requested a waiver that would allow Indian health providers to be paid directly by the State instead of by the health plans in which AHCCCS beneficiaries are enrolled. On September 30, 2010, the State submitted a request for an extension to the Demonstration. The Demonstration is set to expire on September 30, 2011.

Description: The entire Arizona Medicaid Program operates as a Medicaid Section 1115 demonstration and includes a HIFA amendment that allows for coverage of parents and children with title XXI funds. In addition, Arizona has a targeted family planning demonstration for women with incomes up to 133% 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% of its Medicaid expenditures into managed care. ■

Arkansas Family Planning

Project No: 11-W-00074/06
Project Officer: Rebecca Burch Mack
Period: June 1996 to January 2012
Funding: $ 0.00
Principal Investigator: Eugene Gessow
Award: Waiver-Only Project
Awardee: Division of Medical Services, Department of Health and Human Services
700 Main Street
Little Rock, AR 72203

Status: As of September 30, 2010, 61,104 individuals were enrolled in the Demonstration.

Description: This demonstration extends Medicaid coverage for family planning services to uninsured women of childbearing age who are not otherwise eligible for Medicaid, SCHIP, Medicare or the State's HIFA demonstration and who have no other creditable coverage, and whose family income is at or below 200% FPL. ■

Arkansas Safety Net Benefit Program

Project No: 21-W-00051/06 and 11-W-00214/06
Project Officer: Mark Pahl
Period: March 2006 to September 2011
Funding: $ 0.00
Principal Investigator: Eugene Gessow
Award: Waiver-Only Project
Awardee: Division of Medical Services, Department of Health and Human Services
700 Main Street
Little Rock, AR 72203

Status: As of June 30, 2010, 419,681 individuals were enrolled in the demonstration. On September 29, 2010, the State requested to renew the demonstration, which is scheduled to expire September 30, 2011. The State's request is under review.

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% 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. ■

Arkansas TEFRA-Like 1115

Project No: 11-W-00163/06
Project Officer: Mark Pahl
Period: October 2002 to December 2013
Funding: $ 0.00
Principal Investigator: Eugene Gessow
Award: Waiver-Only Project
Awardee: Division of Medical Services, Department of Health and Human Services
700 Main Street
Little Rock, AR 72203

Status: As of June 30, 2010, 3,098 individuals were enrolled in the demonstration. On December 14, 2010, CMS granted an extension of the Demonstration through December 31, 2013.

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-00115/06
Project Officer: Andrea Casart
Period: August 1997 to December 2013
Funding: $ 0.00
Principal Investigator: Eugene Gessow
Award: Waiver-Only Project
Awardee: Division of Medical Services, Department of Health and Human Services
700 Main Street
Little Rock, AR 72203

Status: On December 22, 2010, CMS approved an extension for this demonstration, through December 31, 2013, which included approval for a State option to expand eligibility to children up to and including 250% FPL.

Description: The ARKids B demonstration provides coverage for Medicaid expansion (CHIP) children through age 18 with family income above the Medicaid income level up to and including 200% FPL. The State has an option to extend eligibility up to and including 250% FPL. The demonstration utilizes the same provider system as the traditional Arkansas Medicaid program and operates as a primary care case management model. ■

Autism Spectrum Disorders (ASD) Services Contract

Project No: HHSM-500-2006-00007I/0009
Project Officer: Ellen Blackwell
Period: September 2008 to September 2011
Funding: $540,046.00
Principal Investigator: Denise Juliano-Bult
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: Efforts are presently underway on task one, the Environmental Scan, and optional task A, the report on states' services to individuals with ASD. The contract was modified to exercise optional task B. The estimated total cost was increased by $154,245 from $385,801 to $540,046. The period of performance was extended to September 24, 2011.

Description: This purpose of this task order is to obtain information about support and services to individuals with ASD, and their families. The Centers for Medicare and Medicaid Services (CMS) have requested proposals addressing the completion of required tasks and optional tasks that include: an environmental scan, assessment of state services, design of model programs, development of an ASD web portal, meetings, and production of various reports. The task order will help CMS: gain valuable information regarding the evidence-based nature of support and services to individuals with ASD, assess state systems delivery and gaps in services to people with ASD, develop model programs for children and adults with ASD, and create an ASD information portal. It is expected that the first task, the environmental scan, will be completed in year one. Optional tasks may be awarded in future fiscal years as funding becomes available. Each task is expected to be completed in a one year period; thus, the task order could range from one to four years, dependant on the number of optional tasks chosen by CMS. The final report and final meeting will pertain to all tasks completed by the contractor. The contractor selected for the ASD project is IMPAQ, International. The contractor has submitted a final workplan that spans the full task order which describes how the tasks build on one another. The Environmental Scan involves an examination of empirical literature to determine which ASD-related services have been shown to be safe and effective for three key groups: children, youth, and adults. It will also assess how evidence based practices map to Medicaid services with regard to provider types/ qualifications, service settings, and the amount/duration of support and services. Interventions will be ranked according to an ordinal scale and categorized into two groups: descriptive and analysis reports. Regarding optional task A, the contractor will analyze ASD-related services and supports in nine states, creating a template for future efforts on a national scale to assess the "state" of ASD support and services. Program, budget, and other structures will be included in this snapshot of how ASD support and services are delivered in various states. It is expected that both individual data on the selected states, and the future potential to track data in certain areas for all states, will provide helpful information for policymakers regarding current ASD services, and how ASD support and services trends may change over time. ■

Autism Spectrum Disorders (ASD) State Of The States

Project No: HHSM-500-2006-00009I/HHSM-500-T0002
Project Officer: Ellen Blackwell
Period: September 2009 to January 2011
Funding: $349,927.00
Principal Investigator: Myra Tanamor
Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is complete.

Description: This project measured ASD activity in 50 states, and collected information on current services for people with ASD, policies that affect people with ASD, and utilization of public supports for people with ASD. A Technical Expert Panel (TEP) that includes national ASD experts from across the U.S. provided advice to the contractor and CMS as the project progressed. ■

Bedford Ride Program

Project No: 1C0CMS030271/01
Project Officer: Pamela Pope
Period: July 2008 to December 2010
Funding: $161,812.00
Principal Investigator: Brenda Lipscomb
Award: Grant
Awardee: Central Virgina Area Agency on Aging, Inc.
3024 Forest Hills Circle
Lynchburg,VA 24501

Status: This grant ended on December 31, 2010. OAGM will close out after final reports are received. The first period of performance (POP) for this project was from July 27, 2008 to December 31, 2009, with an award amount of $66,812. The continuation extended the POP to December 31, 2010, with an additional award amount of $95,000, for a total award of $161,812.

Description: This project will provide non-emergency medical transportation for Bedford City and County citizens. The transportation will include trips to and from dialysis treatments, cancer treatments, and preventative medical diagnosis services. It is anticipated that to carry out this service, 14,200 volunteer service hours will be required. The number of one-way trips will be approximately 10,000. The number of miles traveled will be approximately 186,333. These trips will be provided to those who have no other means of transportation. Vehicles and oversight will be provided by the Central VA Area Agency on Aging with drivers and dispatch operations carried out by volunteer groups throughout the county and city. ■

California Family Planning, Access, Care, and Treatment Program

Project No: 11-W-00143/09
Project Officer: Juliana Sharp
Period: December 1999 to January 2011
Funding: $ 0.00
Principal Investigator: Toby Douglas
Award: Waiver-Only Project
Awardee: Medical Care Services, Department of Health Services
1501 Capitol Avenue, 6th Floor, MS 0002
Sacramento, CA 95814

Status: This Demonstration expired on September 30, 2004, and has been operating under a series of short-term extensions, pending approval of a full three year extension. The State submitted a placeholder State plan amendment on September 30, 2010 to take up the State plan family planning eligibility option. As of March 2009, over 1.8 million individuals were enrolled in the Demonstration.

Description: This Demonstration expands Medicaid coverage for family planning services to men and women of childbearing age with incomes up to 200% FPL. ■

California's Bridge to Reform

Project No: 11-W-00193/09
Project Officer: Steven Rubio
Period: August 2005 to October 2015
Funding: $ 0.00
Principal Investigator: Toby Douglas
Award: Waiver-Only Project
Awardee: Medical Care Services, Department of Health Services
1501 Capitol Avenue, 6th Floor, MS 0002
Sacramento, CA 95814

Status: On November 2, 2010, CMS granted a five year extension to this Demonstration, including significant changes proposed by the State. The renewed Demonstration's approval period is November 1, 2010 through October 31, 2015.

Description: This demonstration restructures the financing of the State share of Medicaid expenditures for governmental hospitals, continues the authority of the State to selectively contract with hospitals for negotiated rates, and creates a Safety Net Care Pool (SNCP) to fund payments to providers for the unreimbursed cost of caring for the uninsured, a Coverage Initiative (CI), and Designated State Health Programs (DSHP). The Demonstration was originally approved in August 2005 for a five year period, ending August 31, 2010. Effective November 1, 2010, the Demonstration was extended for an additional five years, and several features were added. Under the renewed Demonstration, the State is authorized to create a Low Income Health Program (LIHP), for the purpose of expanding coverage in more counties than in Demonstration as originally approved. The LIHP covers individuals through two programs. The Medicaid Coverage Expansion covers individuals age 19-64 with incomes at or below 133% FPL. The State must require the counties to reduce cost sharing and strengthen services relative to the original CI, in anticipation that these individuals will transition to the more significant coverage options available in 2014 under the Affordable Care Act. The second component consists of the existing CI (now the Health Care Coverage Initiative, or HCCI), redesignated to cover individuals with incomes between 130 and 200% FPL. The extended Demonstration permits the State to mandatorily enroll Seniors and People with Disabilities (SPDs) into managed care plans for primary and acute care services, with safeguards and protections to ensure SPD-specific network readiness and access to quality care. The State's existing Medicaid managed care programs for families with children and foster care children, and selected specific managed care programs (California Health Insuring Organizations, Health Plan of San Mateo, Santa Barbara San Luis Obispo Regional Health Authority, and Two Plan Geographic Managed Care), are subsumed into the Demonstration. The SNCP budget was expanded to $15.33 billion for the five year extension period (compared to 7.66 billion in the initial approval period), to ensure support for the provision of health care by county hospitals, clinics, and other providers. The additional funds will also support the establishment of new infrastructure investment payments and an incentive payment pool for public hospitals (the Delivery System Reform Incentive Pool), and funding for additional DSHP. To assure budget neutrality, total SNCP spending over the five years may not exceed the amount saved through the use of managed care, combined with the difference between the upper payment limit amounts the State could (but does not) pay to institutional providers subject to the upper payment limit. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300066/01
Project Officer: Diana Ayres
Period: September 2006 to December 2010
Funding: $5,402,270.00
Principal Investigator: Jean Ford
Award: Cooperative Agreement
Awardee: Johns Hopkins University,
Bloomberg School of Public Health
615 N. Wolfe St, Room E6650
Baltimore, MD 21205

Status: Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects: 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures, reduce racial and ethnic health disparities in the quality of health care services provided to target individuals, and increase beneficiary and provider satisfaction, then the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Given that the demonstration sites initially took so long to enroll participants, the limited time for the interventions being tested to take effect, and insufficient participant Medicare claims data to permit measurement of the demonstration's impact, the first two Reports to Congress have been unable to definitively address either of the above two issues yet. The third and final Report to Congress is due September 2012. The four year demonstration, which started September 2006, ended December 2010.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300067/01
Project Officer: Diana Ayres
Period: September 2006 to December 2010
Funding: $3,720,105.00
Principal Investigator: Randall Burt
Award: Cooperative Agreement
Awardee: University of Utah, Huntsman Cancer Institute
2000 Circle of Hope
Salt Lake City, UT 84112

Status: Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects: 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase beneficiary and provider satisfaction, the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Since the initial Report to Congress was due so soon after the start of the demonstration, the Report was unable to address either of the above two issues. This was largely due to the limited time for the interventions being tested to take effect and the insufficient Medicare claims data experience of participants to permit measurement of the demonstration's impact. The next Report to Congress was deivered in September 2010. The four year demonstration, which started September 2006, ended December 2010.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300068
Project Officer: Diane Merriman
Period: September 2006 to March 2011
Funding: $5,471,746.00
Principal Investigator: Robert Chapman
Award: Cooperative Agreement
Awardee: Henry Ford Health System, Josephine Ford Cancer Center
2799 West Grand Blvd, M2
Detroit, MI 48202

Status: Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures, reduce racial and ethnic health disparities in the quality of health care services provided to target individuals, and increase beneficiary and provider satisfaction, then the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Given that the demonstration sites initially took so long to enroll participants, the limited time for the interventions being tested to take effect, and insufficient participant Medicare claims data to permit measurement of the demonstration's impact, the first two Reports to Congress have been unable to definitively address either of the above two issues yet. The third and final Report to Congress is due September 2012. The four year demonstration, which started September 2006, is scheduled to end March 2011.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300069/01
Project Officer: James Coan
Period: September 2006 to March 2011
Funding: $732,202.00
Principal Investigator: Sandra Brazzel
Award: Cooperative Agreement
Awardee: Molokai General Hospital
P O Box 408
Kaunakakai, HI 96748

Status: Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures, reduce racial and ethnic health disparities in the quality of health care services provided to target individuals, and increase beneficiary and provider satisfaction, then the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Given that the demonstration sites initially took so long to enroll participants, the limited time for the interventions being tested to take effect, and insufficient participant Medicare claims data to permit measurement of the demonstration's impact, the first two Reports to Congress have been unable to definitively address either of the above two issues yet. The third and final Report to Congress is due September 2012. The four year demonstration, which started September 2006, is scheduled to end March 2011.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS200070/01
Project Officer: Kathleen Connors de laguna
Period: September 2006 to March 2011
Funding: $2,852,878.00
Principal Investigator: Ana Natale-Pereira
Award: Cooperative Agreement
Awardee: New Jersey Medical School
30 Bergen St, ADMC 614
Newark, NJ 07103

Status: The four year demonstration, which started September 2006, is currently phasing down activities and will end March 31, 2011. Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects: 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures, reduce racial and ethnic health disparities in the quality of health care services provided to target individuals, and increase beneficiary and provider satisfaction, then the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Because the initial Report to Congress was due so soon after the start of the demonstration, the Report was unable to address either of the above two issues, given the limited time for the interventions being tested to take effect and insufficient participant Medicare claims data to permit measurement of the demonstration's impact. The final Report to Congress is due September 2012.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300065/01
Project Officer: Kathleen Connors de laguna
Period: September 2006 to March 2011
Funding: $5,260,361.00
Principal Investigator: Lovell Jones
Award: Cooperative Agreement
Awardee: University of Texas, M D Anderson Cancer Center
1515 Holcombe Blvd, Unit 639
Houston, TX 77030

Status: The four year demonstration, which started September 2006, is currently phasing down activities and will end March 31, 2011. Section 122(b)(3) of BIPA provides that if the initial Report to Congress on the demonstration projects contains an evaluation that the demonstration projects: 1) reduce Medicare expenditures under title XVIII of the Social Security Act or 2) do not increase Medicare expenditures, reduce racial and ethnic health disparities in the quality of health care services provided to target individuals, and increase beneficiary and provider satisfaction, then the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects. Because the initial Report to Congress was due so soon after the start of the demonstration, the Report was unable to address either of the above two issues, given the limited time for the interventions being tested to take effect and insufficient participant Medicare claims data to permit measurement of the demonstration's impact. The final Report to Congress is due September 2012.

Description: Section 122 of BIPA 2000 mandated this demonstration to test the feasibility of implementing patient navigation in Medicare to reduce cancer screening, diagnosis, and treatment disparities. While the navigation programs offered by the six demonstration sites vary, their services include assistance in scheduling appointments, providing transportation assistance, coordination of care among providers, arranging for translation/interpretation services, and providing other services to overcome the barriers encountered during cancer care. ■

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: $ 29,700.00
Principal Investigator: Robert Godbout
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

Status: Stepwise Systems, Inc. is performing the technical analysis for this project. The contractor has performed analyses, creating case-mix adjusters for the first four years of the five year demonstration.

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 incorporated into the demonstration in an effort to make the payment methodology more equitable to participating hospitals. ■

Changes in Out-of-Pocket Health Care Spending by Medicare Beneficiaries Following Implementation of the Part D Prescription Drug Program

Project No: CMS-ORDI-2010-1
Project Officer: Gerald Riley
Period: July 2009 to July 2010
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: Findings were presented at a poster session at the annual meeting of AcademyHealth in June 2010 in Boston, Massachusetts. Study findings are summarized below: Abstract Background: The Medicare Part D benefit was designed to reduce out-of-pocket drug costs at a time when out-of-pocket spending on health care

had been rising rapidly. Purpose: To compare out-of-pocket costs for prescription drugs and for all health care before and after implementation of Medicare Part D. Data: Medicare Current Beneficiary Survey, 2005 and 2006. Methods: The study sample consisted of community-dwelling individuals who participated in the survey in both 2005 and 2006 (N=6,347). Three cohorts were defined based on their Part D status in 2006: Part D enrollees without a low income subsidy (LIS); Part D enrollees with LIS; and non-Part D enrollees. Primary outcome measures were changes in monthly out-of-pocket costs for prescription drugs and changes in total out-of-pocket costs for health care (including health insurance and Medicare premiums), between 2005 and 2006. Results: Average monthly out-of-pocket drug costs declined by $17 (45 percent) and $12 (15 percent) for Part D enrollees with and without LIS respectively. Non-Part D enrollees experienced no significant change after inflation adjustment. Reductions in out-of-pocket drug costs were greatest among Part D enrollees who lacked drug coverage in 2005. Total out-of-pocket costs for health care increased seven percent for Part D enrollees without LIS and did not change significantly for Part D enrollees with LIS. Conclusions: Beneficiaries who enrolled in the Part D program in its first year experienced reductions in out-of-pocket drug costs, but not reductions in total out-of-pocket costs.

Description: The purpose of the study is to compare out-of-pocket spending for prescription drugs for all health care before and after implementation of Part D, using the Medicare Current Beneficiary Survey Cost & Use files for 2005 and 2006. The study sample consists of community-dwelling individuals who participated in the survey in both 2005 and 2006. Three cohorts were defined on the basis of their Part D status in 2006: Part D enrollees without a low income subsidy (LIS); Part D enrollees with LIS; and non-Part D enrollees. Primary measures were changes in monthly out-of-pocket costs for prescription drugs and changes in total out-of-pocket costs for health care (including health insurance and Medicare premiums), between 2005 and 2006. ■

Children's Dental Home Demonstration Project, The

Project No: 1C0CMS330730-01-00
Project Officer: Beth Benedict
Period: June 2010 to May 2011
Funding: $250,000.00
Principal Investigator: Lawrence Carl
Award: Grant
Awardee: Iowa Dental Association
5530 West Pkwy, Ste 100
Johnston, IA 50131

Status: The project is underway.

Description: This program will provide hundreds of children in Scott County, Iowa with dental screenings and necessary preventive, diagnostic, treatment and emergency service. It is actively identifying the dental providers who will be willing to participate in the Medicaid reimbursement program for dental services and who will care for young children. The program is also working with the Medicaid Offices to verify children who are Medicaid enrolled and not receiving dental services. The program is applying their approach to Scott County as a pilot for broadening it to other parts of the state at a future time after the results of this grant are available. ■

Chronic Condition Data Warehouse (CCW) and the Research Data distribution Center (RDDC)

Project No: HHSM-500-2010-000011/HHSM-500-T0001
Project Officer: Spike Duzor
Period: April 2010 to September 2011
Funding: $4,696,114.00
Principal Investigator: Todd Goeldner
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: The total estimated cost for this task order has increased by $599,525, from $4,146,589 to $4,746,114. The period of performance has been extended to September 29, 2011.

Description: This task order will combine the Chronic Condition Data Warehouse (CCW) and the Research Data Distribution Center (RDDC). This task will include: Start-Up Activities and Transition Planning for 60 days; Information Security; Infrastructure Tasks; Operating Tasks; Management; and Transition Tasks. This task has initially been awarded for a one year period, but has four one year options included. ■

Chronic Condition Warehouse Contract (CCW)

Project No: HHSM-500-2008-00016C
Project Officer: Spike Duzor
Period: September 2008 to December 2010
Funding: $2,382,800.00
Principal Investigator: Gary Newell
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: This contract is currently being recompeted as an Indefinite Delivery/Indefinite Quantity (IDIQ) contract to combine the CCW and Research Data Distribution Center (RDDC). The tentative award date of the new contract is March 2010. This contract has ended and been replaced by HHSM-500-2010-00001I, HHSM-500-T0001

Description: This contractor will operate the Chronic Condition Warehouse (CCW) database 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. ■

Chronically Critically Ill Population Payment Recommendations (CCIP-PR): Development of Multiple Setting Payment Recommendations Targeting the Chronically Critically Ill Population

Project No: HHSM-500-2006-00008I/HHSM-500-T0001
Project Officer: Shannon Flood
Period: September 2009 to September 2012
Funding: $1,664,586.00
Principal Investigator: David Kennell
Ed Drozd
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park Drive, Suite 505
Falls Church,VA 22042

Status: The contractor is studying chronically ill populations of Medicare beneficiaries.

Description: The Chronically Critically Ill Population Payment Recommendations (CCIP-PR) project's objective is to develop payment reform recommendations for providers treating medically complex, chronically critically ill patients requiring extended hospital-level care. Payment reform recommendations should cross multiple provider settings which may include General Acute Care Hospitals, Long-term Care Hospitals, Inpatient Rehabilitation Facilities, and Skilled Nursing Home Facilities. ■

Clinical Quality Data Collection/Management for the EHR Demonstration

Project No: HHSM-500-2005-00029I/0013
Project Officer: Debbie Vanhoven
Period: May 2008 to September 2015
Funding: $1,078,321.00
Principal Investigator: Michael Trisolini
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The recruitment period for practices in the four Phase I sites (including Louisiana, Maryland, the District of Columbia, 11 counties in S.W. Pennsylvania and South Dakota, and specific counties in bordering states) ended November 26, 2008. The demonstration began in these sites on June 1, 2009, and will continue through May 31, 2014. Plans to implement a second phase of the demonstration in eight additional locations were canceled as a result of the passage of the American Recovery and Reinvestment Act of 2009. However, Phase I is proceeding as originally planned. This contract has been modified to reflect changes in the original contracted scope of work due to cancellation of Phase II of the demonstration.

Description: This task order supports the Centers for Medicare & Medicaid Services (CMS) in implementing the Electronic Health Records (EHR) demonstration project and provides technical and administrative support to CMS in the collection and management of clinical quality data submitted by participating physician practices. This contractor is responsible for maintaining and updating, as necessary, databases and files used for the collection and management of clinical quality data measures reported by participating primary care practices in the demonstration. In addition, the contractor is

responsible for scoring the data measures (both claims-based and non claims-based measures) for determining incentive payments under the demonstration, as well as data validation/audit activities. ■

Clinical Quality Measure Data Collection and Technical Assistance Support for the Medicare Care Management Performance (MCMP) Demonstration

Project No: HHSM-500-2005-00029I/0014
Project Officer: Jody Blatt
Period: September 2008 to January 2011
Funding: $877,622.00
Principal Investigator: Musetta Leung
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 underway. The demonstration ended June 30, 2010, although data collection and other support activities under this contract will continue through FY 2011.

Description: This task order provides ongoing support for the collection and management of clinical quality measure data for the Medicare Care Management Performance demonstration. This demonstration began operations on July 1, 2007 and ended on June 30, 2010. Data collection activities will continue for another year after that date. Initial work for this demonstration was conducted by Research Triangle Institute International (RTI) and its subcontractor, the Iowa Foundation for Medical Care (IFMS) under Contract 500-00-0024, Task Order #13. That initial contract expired on September 30, 2009. ■

CMS Comparative Effectiveness Research Public Use Data Pilot Project

Project No: HHSM-500-2006-00007I/HHSM-500-T0004
Project Officer: Chris Haffer
Period: June 2010 to May 2012
Funding: $8,997,697.00
Principal Investigator: Craig Coelen
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: Phase One files which will be stand alone (non-linked), downloadable files based on 2008 CMS claims data are being developed and rigorously tested and were planned to be available to the public beginning December 2010.

Description: The purpose of this project is to increase access to CMS data through the creation of public use data and a means of accessing these data, while continuing to strictly protect beneficiary and provider confidentiality. The Health Information Portability and Accountability Act (HIPAA) Privacy Rule (PR) specified the 18 items of information that, if removed from a dataset would render it de-identified. There have been assertions that even datasets de-identified to this extent are still "easily" re-identified. The notion that re-identification is easy has made it into mainstream thought on the subject, yet there is little or no basis for this assertion in fact. The purpose of the de-identification challenger is to ascertain whether, and by what means, it would be possible to re-identify Medicare beneficiaries in CMS claims HIPAA-de-identified datasets or "health information that has been de-identified following the requirements for De-identification of Protected Health Information Section 164.514(b)(2)". In making CMS data more accessible it is paramount to ensure that beneficiary and provider privacy and confidentiality are not compromised. Much of the data that comes to CMS is personally identifiable. Various laws, regulations, and court rulings govern accessibility to these data. Any effort to improve access to CMS data needs to carefully adhere to all requirements and restrictions to be sure beneficiaries are protected. A central part of the current project is to ensure that identifying data are appropriately masked to be sure that beneficiary and provider privacy is strictly protected. This contract will ascertain whether, and by what means, it would be possible to re-identify a HIPAA-de-identified dataset, or health information that has been de-identified in accordance with the

requirements for De-identification of Protected Health Information as stated in 45 CFR Section 165.514. ■

CMS Databases to Support Health Services Research

Project No: HHSM-500-2010-000011
Project Officer: Spike Duzor
Period: March 2010 to March 2015
Funding: $ 50,000.00
Principal Investigator: Todd Goeldner
Award: Master Contract, Base
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: The IDIQ is used to award tasks involving use of the CCW/RDDC data. The period of performance is five years from the date of award. Although each task is managed independently, approval from the IDIQ project officer is required prior to utilization of the IDIQ.

Description: This contract is an Indefinite Delivery Indefinite Quantity (IDIQ) Award which encompasses a wide variety of tasks including database development, database management, data dissemination and data support. The broad activities to be included in the IDIQ contract are: Infrastructure; Loading Data; Data Distribution; Data Analysis; Data Enhancement; and CMS Research Demonstration Support. Individual task orders will be awarded as the need becomes available. ■

CMS Episode Grouper for Medicare - Approach B

Project No: HHSM-500-2010-00063C
Project Officer: Jesse Levy
Period: September 2010 to December 2011
Funding: $1,462,637.00
Principal Investigator: Carol Simon
Award: Contract
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: The project is underway.

Description: The goal of this contract is to construct a comprehensive public use episode grouper. The grouping processes and logic shall be readily understandable, transparent, and comprehensible to the intended audience of physicians, policy makers, and health care administrators. It shall be valid and reliable, and have a reasonable number of homogenous episode groupings. Conceptually, episode grouping is comprised of three sub-systems or modules: clinical logic, episode construction logic, and the risk adjustment method. Each of these subsystems can stand on its own, or be integrated with the other components into a software program that groups claims into episodes. The Approach B is organized by these components. This contract is for only episode grouping software and its components. Elements of a profiling system, e.g., attribution rules, benchmarking, standardized costs, etc., may be considered in the design of data systems that will be part of the grouper software's output (with input from CMS). ■

CMS Medicaid Analytic Extract Data Warehouse to Support Comparative Effectiveness Research

Project No: HHSM-500-2010-000011/HHSM-500-T0003
Project Officer: Kim Elmo
Period: June 2010 to June 2012
Funding: $10,249,783.00
Principal Investigator: Cindy Weigel
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: This task is on target and is fully-funded with ARRA money.

Description: This task will build a Medicaid and Children's Health Insurance Program (CHIP) research database with data dissemination capability to support CER projects. CMS has a wealth of administrative Medicaid and CHIP data that can be organized to support CER. The Medicaid and CHIP programs contain a rich and diverse population that lends itself to CER. Over 40% of all births in the United States are financed by Medicaid. A large percent of the nation's young families and people with disabilities are also Medicaid and CHIP recipients. MAX data are person-level data files on Medicaid eligibility, service utilization and payment information. MAX transforms the state-submitted Medicaid and CHIP data into individual-level use and

cost research-ready data in five file types: Personal Summary (including eligibility), Inpatient Hospital, Long-Term Care (institutional services), Pharmacy, and Other Services (physician services, therapies, DME, and community long-term care services). MAX Data Warehouse objectives:

- Establish a MAX data warehouse and load MAX 1999-2007 data.
- Add additional years of MAX data as they become available.
- Build a data extraction system to deliver customized MAX data extract files with minimum data necessary to the research community.
- Support CER researchers by providing MAX data. ■

Colorado Adult Prenatal Coverage and Premium Assistance in CHP+

Project No: 21-W-00014/08
Project Officer: Stacey Green
Period: September 2002 to January 2011
Funding: $ 0.00
Principal Investigator: William Heller
Award: Waiver-Only Project
Awardee: Department of Health Care Policy and Financing, Office of Child Health Plan Plus
1570 Grant Street
Denver, CO 80203-1818

Status: The demonstration expired on September 30, 2009, and has been continued through temporary extensions as terms for a longer extension are discussed. As of October 1, 2010, 1,623 pregnant women and 133 children were enrolled in this demonstration.

Description: This demonstration expands coverage under CHIP to pregnant women with incomes above 133% FPL and up to and including 200% FPL. It also provides a premium assistance option to CHIP children with incomes up to and including 200% FPL. ■

Comparative Effectiveness Research Contract - CCW and Death Certificate Data

Project No: HHSM-500-2010-000011/HHSM-500-T0002
Project Officer: Michelle Ruff
Period: June 2010 to June 2012
Funding: $15,500,000.00
Principal Investigator: Cindy Weigel
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: This task is on target and is fully-funded with ARRA money. Additional funds will be added for the purposes of converting ICD-9 to ICD-10. This additional money will not be ARRA funding.

Description: This task will provide Comparative Effectiveness Research (CER) enhancements on the CCW database that already exists under Task #1 of the umbrella contract. In addition to the CER enhancements, this task order includes the purchase of National Death Index data from the National Center for Health Statistics (NCHS). CMS has an application with NCHS to obtain this data. The contractor will be responsible for providing the funding (via a passthrough from CMS to NCHS) for the data and incorporating the data into the database for CER projects. The contractor will be responsible for maintaining the CERT enhanced database and making the data available to internal and external CER researchers. ■

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 2010
Funding: $ 50,000.00
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, 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. The demonstration was extended for two additional years in order to further test the cost effectiveness of the case and disease management intervention.

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 who account for a major proportion of Medicare expenditures. Iowa was one of 15 sites selected as 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 June 2013
Funding: $ 0.00
Principal Investigator: Kenneth Coburn
Award: Cooperative Agreement
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. The demonstration has been extended to June 30, 2013 in order to further test the effectiveness of Health Quality Partners' coordinated care interventions. It is the only remaining site under the demonstration.

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 who account for a major proportion of Medicare expenditures. Health Quality Partners of Doylestown, Pennsylvania 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. ■

Delaware Diamond State Health Plan

Project No: 11-W-00036/03
Project Officer: Juliana Sharp
Period: May 1995 to January 2011
Funding: $ 0.00
Principal Investigator: Rosanne Mahaney
Award: Waiver-Only Project
Awardee: Division of Medical Assistance, Department of Health and Human Services
1985 Umstead Drive, 2517 Mail Service Center
Raleigh, NC 27699-2517

Status: The State submitted a request for a three year extension on July 1, 2009. The State is not proposing any significant changes to the Demonstration as part of its renewal request. The previous three year extension for the Demonstration expired on December 31, 2009, and the Demonstration has been operating under temporary extension since that time. The latest temporary extension expired on January 31, 2011. Discussion continues between the State and CMS concerning a possible longer-term extension.

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% 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. ■

Demonstration of Home Health Agencies Settlement for Dual Eligibles for the State of Connecticut

Project No: 95-W-00086/01
Project Officer: Diane Ross
Period: January 2001 to December 2010
Funding: $ 0.00
Principal Investigator: Kristine Ragaglia
Award: Waiver-Only Project
Awardee: Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Status: The demonstration ended on December 31, 2010 and was not extended for CT.

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 for by the states' Medicaid agencies. This sampling will be used in lieu of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim that 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. ■

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

Project No: 95-W-00084/02
Project Officer: Diane Ross
Period: January 2002 to December 2011
Funding: $ 0.00
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 Fiscal Years 2000 through 2007. The first year of arbitration which represents the final level of appeal was completed in November 2008. New York has received settlements on all of the out years through 2005. Final settlements are pending on 2006 and 2007. The demonstration was extended for NY and covers FYs 2008 - 2010.

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 service 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 Maintain Independence and Employment - Texas

Project No: 11-P-91420/06
Project Officer: Claudia Brown
Period: March 2007 to December 2009
Funding: $21,000,000.00
Principal Investigator: Dena Stoner
Award: Grant
Awardee: Texas, Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247

Status: At the present time, the State is in the process of analyzing study data to produce a comprehensive State level evaluation report. Demonstration services stopped at the end of 2009.

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 (SSA). 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 to Maintain Independence and Employment Data Analysis

Project No: HHSM-500-2005-00025I/0003
Project Officer: Susan Radke
Period: June 2007 to May 2011
Funding: $5,365,340.00
Award: Task Order
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The project is underway. Funding has been increased by $339,904, from $5,025,436 to $5,365,340. The period of performance has been extended to May 31, 2011.

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. ■

Design and Implementation Support for the Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration Project

Project No: HHSM-500-2005-00029I/HHSM-500-T0010
Project Officer: Linda Lebovic
Period: September 2010 to September 2011
Funding: $498,006.00
Principal Investigator: John Kautter
Award: Task Order
Awardee: Research Triangle Institute, (DC)
1615 M Street, NW, Suite 740
Washington, DC 20036-3209

Status: The project is in the design phase.

Description: The purpose of this Task Order is to assist the Centers for Medicare & Medicaid Services (CMS) in meeting the requirements of Section 3113 of the Affordable Care Act of 2010 which mandates a demonstration project under Part B title XVIII of the Social Security Act under which separate payments are made for complex diagnostic laboratory tests. Under the demonstration project, the Secretary shall establish appropriate payment. Specifically, the purposes of this task order are to assist CMS in the design and implementation of the demonstration. The term "separate payment" means direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital if the test is performed after such period of hospitalization and if separate payment would not otherwise be made under title XVIII of the Social

Security Act. A complex diagnostic laboratory test means a diagnostic laboratory test that:

1) is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

2) has no alternative test having equivalent performance characteristics;

3) is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code;

4) is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and

5) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)).

The demonstration project begins on July 1, 2011, and operates for a two year period. The statute provides a maximum of $1,000,000,000 for direct payments to laboratories. A Report to Congress is required not later than two years after the completion of the demonstration project. The report will assess of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures under title XVIII of the Social Security Act. Work performed under this Task Order shall address design and operational approaches to: 1) determining payment rates for laboratory services under the demonstration; 2) monitoring payment to laboratories for services under the demonstration; and 3) collaborating with CMS staff experts and the CMS evaluation contractor. ■

Design, Development and Implementation Support for the Appropriate use of Imaging Services Demonstration

Project No: HHSM-500-2005-00024I/HHSM-500-T0002
Project Officer: Linda Lebovic
Period: April 2009 to April 2014
Funding: $3,169,371.00
Principal Investigator: Charlie Bruetman
Award: Task Order (MRAD)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: Proposals from convener applicants were due September 27, 2010. CMS will announce the award of the demonstration sites via the project listserv and webpage.

Description: The scope of work is for an initial 12-month period of performance for technical assistance on the design, development, and pre-implementation work for the Appropriate use of Imaging Services demonstration. The contract will allow CMS to design the demonstration and obtain the necessary approvals to implement the demonstration which is scheduled to run January 1, 2010 through December 31, 2011. The contract contains a 30 month option for technical assistance to support the implementation of the demonstration as well as close-out activities. The design, development, and implementation support contractor selected for this contract will be prohibited from applying for the evaluation contract and agrees to work collaboratively with the evaluation contractor. Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates an Appropriate Use of Imaging Services demonstration project. The goal of the demonstration is to collect data regarding physician use of advanced diagnostic imaging services to determine the appropriateness of services in relation to established criteria and physician peers. ■

Design, Development Support for the Independence at Home Demonstration

Project No: HHSM-500-2005-00029I/HHSM-500-T0012
Project Officer: Linda Colantino
Period: September 2010 to September 2011
Funding: $786,360.00
Principal Investigator: Edith Walsh
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: CMS and the contractor are developing the design of the demonstration including the Waiver Cost Package. We have conducted site visits and held a Technical Expert Panel meeting to discuss the payment structure.

Description: This task order is for an initial 12 month period of performance for technical assistance on the design, development, and implementation work for the Independence at Home Demonstration Program. This Task Order allows CMS to design the demonstration

and obtain the necessary approvals to implement the demonstration. The Task Order contains a 48 month option wherein the implementation contractor shall be responsible for the technical assistance to support the diverse tasks required for implementing and operating the demonstration. ■

Design, Development, and Implementation Support for the Demonstration Project on Community Health Integration Models in Certain Rural Counties

Project No: HHSM-500-2006-00007I/HHSM-500-T0005
Project Officer: Siddhartha Mazumdar
Period: September 2010 to September 2013
Funding: $1,064,912.00
Principal Investigator: Donald Nichols
Award: Task Order
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: This project is underway.

Description: The purpose of this contract is to assist CMS in the design, development, and implementation of a demonstration project on community health integration models in certain rural counties. The demonstration will allow eligible entities to test new models for the delivery of health services to improve access to care and better integrate delivery of acute care, extended care, and other essential health care services in rural counties. The demonstration will also provide an opportunity to evaluate regulatory challenges facing providers in rural communities. ■

Designing a System to Monitor Medicare Beneficiaries' Access to Care

Project No: HHSM-500-2006-00008I/HHSM-500-T0002
Project Officer: David Nyweide
Period: June 2010 to August 2011
Funding: $262,402.00
Principal Investigator: David Kennell
Wendy Funk
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park Drive, Suite 505
Falls Church, VA 22042

Status: The project Design Report is completed, and access measures and data analysis files are under construction.

Description: To determine whether beneficiaries may be experiencing difficulty accessing care, the Centers for Medicare and Medicaid Services, with the help of this contract, plans to develop an access monitoring system (AMS). The AMS will measure beneficiaries' realized access to physician services from Medicare claims and self-reported perceptions of access from 1-800-MEDICARE to produce real-time, geographically sensitive measurements of beneficiaries' access to care. These measurements will be used to detect any significant changes in access over time and across geographical areas. ■

Determining Medical Necessity and Appropriateness of Care at Medicare Long Term Care Hospitals (LTCHS)

Project No: HHSM-500-2006-00008I/0003
Project Officer: William Buczko
Period: July 2008 to June 2011
Funding: $1,379,350.00
Principal Investigator: David Kennell
Kathleen Dalton
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park Drive, Suite 505
Falls Church, VA 22042

Status: The patient margins analysis and site visits have been completed. The interim report on these topics was submitted to CMS on October 29, 2010.

Description: Section 114 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173) requires that the Secretary of Health and Human Services conduct a study on the establishment of national long-term care hospital, facility, and patient criteria for determining medical necessity, appropriateness of admission, and continued stay and discharge from long-term care hospitals. The results of the study are to be reported to Congress, together with recommendations for legislation

and administrative action, including timelines for implementation of patient criteria, or other appropriate action by June 30, 2009. The contractor will describe any additional research studies that are needed to answer the research/policy questions raised by the mandate. The research areas to be considered cover Medicare policy areas such as facility classification and conditions of participation, payment systems (including patient classification issues and "bundled" models across individual payment systems), quality of care, and other related topics. Innovative approaches to addressing the key research questions and policy concerns are encouraged. The contractor will provide a discussion of the rationale and methodology proposed for each study. A full research design for additional analyses will be presented after the Report to Congress has been submitted. Data analyses for these additional research analyses will be performed in project years two and three. The contractor shall address, but not limit itself, to examination of the following research questions:

- What facility/patient criteria can be used to uniquely define LTCHs and patients that are appropriate for care in LTCHs?
- What facility criteria are needed to ensure appropriate provisions of care in LTCHs?
- What criteria are needed to determine appropriateness of admissions, discharges, and treatment modalities, medical complexity, quality of care, and improvement potential for patients commonly treated in LTCHs?
- What criteria/reforms are needed to ensure parity in Medicare payments, access to care, and quality of care between patients treated in LTCHs and patients with similar conditions treated in other settings? ■

Developing Outpatient Therapy Payment Alternatives

Project No: HHSM-500-2005-00029I/0012
Project Officer: Ann Meadow
Period: January 2008 to January 2013
Funding: $2,923,940.00
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: A Technical Expert Panel was convened to obtain expert and stakeholder input on the feasibility and value of proposed measures of therapy related information. A Special Open Door Forum (ODF) was held. This ODF introduced to a broad audience the Developing Outpatient Therapy Payment Alternatives (DOTPA) project with a special emphasis on how data will be collected and how facilities, practices, and individual providers may become involved and contribute to the research. A variety of meetings with stakeholders have been conducted to obtain input, disseminate information about the project, and to lay the foundation for recruiting provider participants for the data collection activities. The annual therapy utilization report based on 2007 claims and the DOTPA Project Annual Report were completed and made available to the public (http://optherapy.rti.org/). The data collection design and instrument development were completed and a Paperwork Reduction Act (PRA) package was submitted for approval by the Office of Management and Budget (OMB). The Federal Register notice for public comment on this package was published on October 9, 2009 (Vol 74, No 195, page 52236). Once the PRA package is approved, the contractor will begin data collection. While approval is pending, the contractor is recruiting potential participants in the data collection, developing training materials for participants, and updating the project website http://optherapy.rti.org/.

Description: CMS envisions a new method of paying for outpatient therapy services that is based on classifying individual beneficiary's needs and the effectiveness of therapy services. CMS does not currently collect the appropriate data elements for this type of study, and therefore cannot evaluate or implement this type of approach. However, the therapy community has been working on these issues and may have data relevant to CMS's intended goals. This project will identify, collect and use therapy related information that is tied to beneficiary need and the effectiveness of outpatient therapy service. The ultimate goal of the task order is to develop payment method alternatives to the current cap on outpatient therapy services. The five year contract has three main tasks: 1) identify and collect beneficiary measures of health and functional status which are not available to CMS currently through claims; 2) provide high-level analysis of the annual utilization and expenditures for outpatient therapy services to enable CMS to monitor changes; and 3) use the collected

beneficiary level data to conduct and report analysis that provide the basis for payment method alternatives. ■

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

Project No: 500-00-0024/0019
Project Officer: Linda Lebovic
Period: September 2004 to March 2010
Funding: $1,297,491.00
Principal Investigator: John Kautter
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 Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. Subsection 145 (a) of the law repealed the Medicare Competitive Bidding Demonstration Project for Clinical Laboratory Services. The demonstration web page can be found at: http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1198949

Description: The goals of this task order are to assist CMS in the design (Phase I) and operation (Phase II) of the demonstration. Phase I will assist with demonstration design and solicitation development. Phase II will assist with the operation of bid sites of the demonstration. Section 302(b) of the Medicare Modernization Act amends section 1847(e) (42 U.S.C. 1395w-3)- Competitive Acquisition of Certain Items and Services, to include a demonstration project for clinical laboratory services. The demonstration must apply competitive acquisition for payment for clinical laboratory services, which would otherwise be made under Medicare Part B fee schedule. The payment basis determined for each competitive acquisition area will be substituted for the payment basis. Under this statute, pap smears and colorectal screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA) as mandated in section 353 of the Public Health Service Act are applicable. Contracts will be re-competed every three years and multiple winners are expected in each competitive acquisition area. The statute does not specify the number or location of demonstration sites. The statute does not specify an implementation date. ■

Development and Implementation Support for the Statewide Quality Improvement Network (SQIN) Demonstration

Project No: HHSM-500-2005-00029I/HHSM-500-T0011
Project Officer: Jennifer Brown
Period: September 2010 to September 2012
Funding: $785,066.00
Principal Investigator: Musetta Leung
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: CMS and the contractor are currently developing the design report and waiver cost estimate for this task order.

Description: This task order will provide technical assistance on the design, development, and pre-implementation work for the Statewide Quality Improvement Network (SQIN) Demonstration. The tasks in the statement of work allow the CMS to design the demonstration and obtain the necessary approvals to implement the demonstration. ■

Development of a Medicaid/CHIP Environmental Scanning and Program Characteristics (ESPC) Database

Project No: HHSM-500-2006-00007I/HHSM-500-T0003
Project Officer: David Baugh
Period: March 2010 to August 2013
Funding: $858,436.00
Principal Investigator: Alicia Berkowitz
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: The project team has created the initial prototype of the database for three states which has been reviewed by CMS managers and other interested parties and the ESPC Technical Experts Panel (TEP). These individuals have provided a number of helpful comments. The

project team is now preparing the ESPC database for all states and the District of Columbia with an planned release to the public in the Spring of 2011. The release will occur through the CMS external web page as a downloadable file in Microsoft Access. There will be a user interface so that users do not need to be proficient in Microsoft Access.

Description: The purpose of this task order is to define basic requirements for a Medicaid/CHIP Environmental Scanning and Program Characteristics (ESPC) database that will include an array of Medicaid program characteristics and contextual variables for each of the 50 States and the District of Columbia. ■

Diabetes Literacy and Self-efficacy Screening and Training Project (Diabetes LASST)

Project No: 1HOCMS030309/02-
Project Officer: Richard Bragg
Period: September 2008 to September 2010
Funding: $225,000.00
Principal Investigator: Sylvia Rabionet
Jose Calderon
Award: Grant
Awardee: Nova Southeastern University, College of Pharmacy
3301 College Avenue
Fort Lauderdale, FL 33314

Status: The grant ended on September 29, 2010 under the Hispanic Health Services Research Grant Program. A Final Report was due January 31, 2011.

Description: Type 2 diabetes is a national epidemic affecting an estimated 21 million individuals. The prevalence of diabetes among the Latino population is 1.7 times that of the majority population. The rapid growth of the Latino population suggests that the prevalence of diabetes will continue to rise in the next decades. The total annual economic cost of diabetes in 2007 was estimated to be $174 billion, with $27 billion spent on diabetes care, $58 billion for diabetes complications, and $31 billion for excess general medical costs. The primary objective of the Diabetes Literacy and Self-Efficacy Screening and Training Project (Diabetes LASST) is to test the efficacy of a community-based intervention to improve self-management, perceived self-efficacy, and clinical outcomes for diabetes. The secondary objective is to screen diabetics and a partnered family member who is at risk for diabetes and chronic kidney disease, as part of the care for diabetes. The specific aims are to:

1) test the efficacy of a Pharmacist-Centered Assessment and Reinforcement of Diabetes Self-efficacy (PARDS) intervention at improving diabetes health literacy for Latino diabetics and their family members,

2) promote positive changes in exercise and diet as measured by information in patient logs and follow-up sessions with a pharmacist and,

3) test the efficacy of PARDS at improving perceived self-efficacy and clinical outcomes for Latino diabetic participants. ■

Disproportionate Share Hospital Requirements

Project No: HHSM-500-2010-000011/HHSM-500-T0005
Project Officer: Sean Layne
Period: August 2010 to February 2011
Funding: $499,804.00
Principal Investigator: Cindy Weigel
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: The project is on schedule. CMS has accepted the code that Buccaneer proposed and is now using it to process requests. Project Officer has changed to Sean Layne.

Description: The data to fulfill the Disproportionate Share Hospital (DSH) data requests are extracted from a system of records entitled Medicare Provider Analysis and Review, also known as "MEDPAR" (HHS/HCFA/OIS, 09-07-0009, 65 Fed. Reg. 50548). The MEDPAR system collects and disseminates information necessary "to recalculate Supplemental Security income ("SSI") ratios for hospitals that are paid under the Prospective Payment System ("PPS") and serve a disproportionate share of low-income patients." The purpose of this task order is to provide the Office of Information Services (OIS) within CMS support for the following: (1) Modifying existing SAS programs to correctly process a backlog of approved "Not-for-Pay" requests for the Medicare DSH Report files; and (2) Securely disseminating the DSH data requests processed. The DSH Report backlog is comprised of approximately 1,100 approved requests for cost periods encompassing December 8, 2004. If the approved request reflects a time

period that spans multiple Federal Fiscal Years, the report files disseminated shall include 12 months of data from each federal fiscal year. ■

District of Columbia Childless Adults

Project No: 11-W-00251/3
Project Officer: Robin Preston
Period: October 2010 to December 2013
Funding: $ 0.00
Principal Investigator: John McCarthy
Award: Waiver-Only Project
Awardee: Medical Assistance Administration, Department of Health
825 North Capitol Street, NE, Suite 5135
Washington, DC 20002

Status: The Demonstration was approved on October 28, 2010. On November 1, 2010, the District automatically enrolled eligible participants from the District-funded Alliance Program into the Demonstration.

Description: This demonstration extends health care coverage to non-pregnant, non-disabled adults aged 21 through 64 years, who are residents of the District of Columbia with household incomes that are between 133 and 200% FPL. This coverage is funded by diverting monies that otherwise could have been used to make supplemental payments to disproportionate share hospitals (DSH). ■

District of Columbia Childless Adults Aged 50-64

Project No: 11-W-00139/03
Project Officer: Robin Preston
Period: March 2002 to September 2010
Funding: $ 0.00
Principal Investigator: John McCarthy
Award: Waiver-Only Project
Awardee: Medical Assistance Administration, Department of Health
825 North Capitol Street, NE, Suite 5135
Washington, DC 20002

Status: Demonstration was terminated effective September 30, 2010. The District moved the population to the State plan effective May 1, 2010.

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

District of Columbia Program to Enhance Medicaid Access for Low-income HIV-infected Individuals

Project No: 11-W-00131/03
Project Officer: Robin Preston
Period: January 2001 to December 2010
Funding: $ 0.00
Principal Investigator: John McCarthy
Award: Waiver-Only Project
Awardee: Medical Assistance Administration, Department of Health
825 North Capitol Street, NE, Suite 5135
Washington, DC 20002

Status: The demonstration was extended through December 31, 2010. The District will allow this demonstration to expire because the participants are now Medicaid state plan eligible. A Medicaid State plan amendment was approved to extend Medicaid eligibility to persons described in section 1902(a)(10)(A)(i)(VIII) (childless adults) with incomes up to 133% FPL, effective May 1, 2010.

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. ■

Dual Eligible Environmental scanning & Data Architecture

Project No: HHSM-500-2005-00026I/HHSM-500-T0004
Project Officer: Apryl Clark
Period: September 2010 to August 2011
Funding: $2,120,692.00
Principal Investigator: Brian Burwell
Award: Task Order (RADSTO)
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: The project is underway.

Description: The Affordable Care Act (ACA) established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve the coordination between the Federal government and the states for individuals eligible for Medicare and Medicaid (dual eligibles). The purpose of this contract is to: o Develop state level summary files, pivot tables and state profiles to analyze the utilization and costs for the dual eligible population and provide detailed information on Medicare and Medicaid benefit packages, waivers, and managed care arrangements, as they pertain to dual eligible beneficiaries. o Conduct site visits with states, providers, advocacy groups, and other health care organizations that have experience in integrating care for dual eligibles and identify potential integrated care models for further testing; o Obtain information from beneficiaries, caregivers, and front line health care providers on barriers to integrated care for dual eligibles; and o Development of a data business strategy and requirements to support the collection, sharing, and analysis of data for dual eligibles by the Federal Coordinated Health Care Office (FCHCO), and the states. ■

Efforts to Enhance Availability and Quality of Managed Long Term Care

Project No: HHSM-500-2006-00009I/HHSM-500-T0001
Project Officer: Kathryn Poisal
Period: August 2009 to August 2011
Funding: $413,083.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project was extended through August 25, 2011.

Description: State interest in managed long term care is growing nationally. For the purposes of this Task Order, long term care includes institutional and community-based services identified in 1905(a) of the Social Security Act (the Act), as well as Home and Community based Services (HCBS) available through either 1915(c) or 1915(i) of the Act. Managed long-term care provides states numerous options for the delivery of these services, including providing for prepayment and capitation, risk sharing arrangements and well-designed contract incentives that may aid a state in shifting toward more community-based care. The contractor will work carefully with the Project Officer to ensure the coordinated efforts with other Contractors working on similar subject matter, as well as to ensure the consistent conveyance of CMS rule and policy. This project is an essential step in raising the level of expertise within CMS and states around mechanisms and strong practices for managed long-term care/HCBS. With the demographic phenomena facing the federal government and the states alike, CMS must clearly identify tools and develop expertise in the area of managed long-term care/HCBS. ■

EHR Demonstration IT System Development

Project No: HHSM-500-2008-00056C
Project Officer:
Period: September 2008 to February 2011
Funding: $4,701,592.00
Award: Contract

Status: The contract was extended through February 28, 2011 and additional funding was approved.

Description: The purpose of this contract is to develop a secure Internet-based software and database system to automate the Electronic Health Record (EHR) demonstration's practice enrollment and clinical quality measure data collection activities. CMS is developing this system under the Electronic Health record Demonstration. It should be noted that CMS is not developing an electronic health record under this demonstration. The EHR referenced in the name of the demonstration pertains to the CCHIT-certified EHR system that participating practices will be requried to implement in their offices. Since the system will be Internet-based and will house sensitive and personally identifiable data, security is a crucial aspect of the system development. CMS is concerned about the authentication of users, who will be dispersed throughout the Medicare provider community. CMS is also concerned about the transmission of sensitive financial (e.g. tax identification numbers) and health information over the Internet. ■

End Stage Renal Disease (ESRD) Measures Support Work

Project No: HHSM-500-2005-000311/0001
Project Officer: Thomas Dudley
Period: February 2006 to March 2010
Funding: $3,829,082.00
Principal Investigator: Robert Wolfe
Award: Task Order (MRAD)
Awardee: Arbor Research Collaborative for Health
315 West Huron, Suite 360
Ann Arbor, MI 48103

Status: The contract expired on March 31, 2010.

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. ■

End-Stage Renal Disease (ESRD) Disease Management Demonstration: DaVita/SCAN

Project No: 95-W-00188/09
Project Officer: Siddhartha Mazumdar
Period: January 2006 to December 2010
Funding: $ 0.00
Principal Investigator: Tami Deeb
Award: Waiver-Only Project
Awardee: VillageHealth
1350 Bayshore Hwy. Suite 777
Burlingame, CA 94010

Status: The Medicare Advantage organization began enrolling patients on January 1, 2006. The enrollment as of January 2010 was 437. The demonstration terminated December 31, 2010. The DaVita/SCAN project will continue as a Medicare Advantage plan for calendar year 2011.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration has increased the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. This demonstration has allowed Medicare Advantage (MA) organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis and MA organization partnership must provide all Medicare covered benefits. Organizations serving ESRD patients 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, has been reduced by five percent. This amount is available to the organizations depending on their performance on quality measures. CMS 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 (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 2010
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: Fresenius Medical Care North America (FMCNA)
920 Winter Street
Waltham, MA 02451

Status: The organization had enrolled members between January 1, 2006 and December 31, 2010 when the demonstration ended. The total monthly enrollment in all FMCHP plans in 2010 averaged 704 beneficiaries. FMCHP plans were 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 increased the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. In this demonstration, dialysis companies partnered with Medicare Advantage (MA) organizations to offer MA plans that enroll only beneficiaries with ESRD in specified service areas. The dialysis/MA organization provided all Medicare covered benefits. Organizations serving ESRD patients received 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, was reduced by five percent, which was available to the organizations depending on performance on quality measures. CMS determined six dialysis-related indicators on which performance was 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. ■

Episode Grouper for Medicare

Project No: HHSM-500-2010-00062C
Project Officer: Craig Caplan
Period: September 2010 to December 2011
Funding: $956,401.00
Principal Investigator: Bob Kelley
Award: Contract
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: The kick-off meeting was held on October 22, 2010; data and Evaluation Criteria have been delivered to the contractor.

Description: The goal of this contract is to modify an existing episode grouping software product for use by the Medicare program. The grouping processes and logic shall be readily understandable, transparent, and comprehensible to multiple stakeholders, including physicians, policy makers, and administrators. The logic shall be valid and reliable, and have a reasonable number of homogenous cost groupings (not thousands). Conceptually, episode grouping is comprised of three sub-systems or modules: clinical logic, episode construction logic, and the risk adjustment method. Each of these subsystems can stand on its own, or be integrated with the other components into a software program that groups claims into episodes. The Approach A is organized by these sub-systems. This contract is only for episode grouping software and its components. Elements of a profiling system (attribution rules, benchmarking, standardized costs, etc.) may be considered in the design of data items that will be part of the grouper software's output design. Use of these elements will be determined by the vendor in collaboration with CMS. ■

Episode Grouper for Medicare - Approach B

Project No: HHSM-500-2010-00064C
Project Officer: David Nyweide
Period: September 2010 to December 2011
Funding: $526,902.00
Principal Investigator: James Vertrees
Award: Contract
Awardee: 3M-Health Information Systems
100 Barnes Road
Wallingford, CT 06492

Status: Data and evaluation criteria have been delivered to the contractor by CMS.

Description: The goal of this contract is to construct a new comprehensive public domain episode grouper. The grouping processes and logic shall be readily understandable, transparent, and comprehensible to the intended audience of physicians, policy makers, and health care administrators. It shall be valid and reliable, and have a reasonable number of homogenous episode groupings. Conceptually, episode grouping comprises three sub-systems or modules: clinical logic, episode construction logic, and the risk adjustment method. Each of these subsystems can stand on its own, or be integrated with the other components into a software program that groups claims into episodes. The Approach B is organized by these components. This contract is for only episode grouping software and its components. Elements of a profiling system (i.e., attribution rules, benchmarking, standardized costs, etc.) may be considered in the design of data items that will be part of the grouper software's output with input from CMS. ■

Episode Grouper for Medicare - Approach B

Project No: HHSM-500-2010-00065C
Project Officer: Fred Thomas
Period: September 2010 to December 2011
Funding: $1,377,036.00
Principal Investigator: Christopher Tompkins
Award: Contract
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The project is in the process of developing the logic for the deliverables. Advisory meetings have been held and the grouper software is in the process of being written. The deliverables are required by September 30, 2011.

Description: The goal of this contract is to construct a new comprehensive public domain episode grouper. The grouping processes and logic shall be readily understandable, transparent, and comprehensible to the intended audience of physicians, policy makers, and health care administrators. It shall be valid and reliable, and have a reasonable number of homogenous episode groupings (not thousands). Conceptually, episode grouping is comprised of three sub-systems or modules: clinical logic, episode construction logic, and the risk adjustment method. Each of these subsystems can stand on its own, or be integrated with the other components into a software program that groups claims into episodes. The Approach B is organized by these components. This contract is for only episode grouping software and its components. Elements of a profiling system (i.e., attribution rules, benchmarking, standardized costs, etc.) may be considered in the design of data items that will be part of the grouper software's output (with input from CMS). (Two other Approach B awards are active.) ■

Evaluating the BearingPoint Medication Use Measures in a Medicaid Population

Project No: 1C0CMS030278/01
Project Officer: Dennis Nugent
Period: July 2008 to December 2009
Funding: $286,899.00
Principal Investigator: Benjamin Banahan
Award: Grant
Awardee: The University of Mississippi
135 Faser Hall, School of Pharmacy
Lafayette, MS 38677

Status: The project concluded as scheduled. A final report was planned to be complete in February 2010.

Description: The objective of the study was to use Medicaid administrative claims data to assess whether the medication use measures tested in a Medicare project, conducted by the University of Mississippi, are associated with similar improvements in outcomes and costs in a Medicaid population. ■

Evaluation of Care and Disease Management Under Medicare Advantage

Project No: HHSM-500-2006-00009I/0004
Project Officer: Gerald Riley
Period: August 2007 to November 2009
Funding: $495,016.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project was recently completed. A final report has been received and accepted. The final report can be found here: https://www.cms.gov/Reports/Downloads/Green_2009.pdf.

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 the types of programs, models of care, and disease management utilized by the plans; the population receiving the care and disease management services; the role of the health plans; and what has been learned on the effectiveness of these programs for the Medicare population. The contractor will be responsible for: the analysis of primary data collected via interviews and surveys of, and/or site visits to participating organizations, supplemented by any documents provided by the plans; as well as conducting a review of the available literature. ■

Evaluation of Clinical Risk Groups (CRGs) Episodes as an Approach to Measuring Physician Resource Use

Project No: HHSM-500-2009-00080C
Project Officer: Fred Thomas
Period: September 2009 to March 2011
Funding: $349,234.00
Principal Investigator: James Vertrees
Award: Contract
Awardee: 3M-Health Information Systems
100 Barnes Road
Wallingford, CT 06492

Status: Data have been delivered to the contractor and analysis has begun.

Description: The successful implementation of the Medicare Diagnosis Related Group (DRG)-based Inpatient Prospective Payment System (IPPS) in 1983 clearly demonstrated that bundling of all inpatient services into a single, per case payment amount, creates an effective incentive for hospitals to utilize resources efficiently. Despite the success of the bundling of services inherent in IPPS, there have been limited efforts at creating larger payment bundles that go beyond a single encounter (i.e. beyond an admission or a visit). Payment bundles for an episode of care can provide the opportunity to expand the range of services included in a payment bundle. MedPAC notes, "[B]undling Medicare payment to cover all services associated with an episode of care has the potential to improve incentives for providers to deliver the right mix of services at the right time." (MedPAC, June 2008 Report to Congress). The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to establish a physician feedback program in which physicians would receive confidential information on their resource use based on episodes of care. The initial motivation for developing the CRG classification system was for risk adjustment of capitated payments. However, the development focused on a management tool for Managed Care Organizations (MCOs), since the success of a capitated payment system is dependent on MCOs being able to respond to the incentives in the system and deliver care efficiently and effectively. The classification system that resulted is not only a management tool but can also be used as a basis for risk adjusting capitated payments. Because the high utilizing population is characterized by multiple co-morbid conditions, it is extremely difficult to accurately attribute the use of individual services to a specific health care event. For example, for a patient who has congestive heart failure, diabetes, renal failure, and is hospitalized for acute heart failure, there is considerable ambiguity in identifying precisely which services are related to the heart failure hospitalization episode as opposed to the diabetes or renal failure (e.g., whether a post discharge emergency room visit for syncope related to heart failure, diabetes, or renal failure). As a result, the definition of an episode needs to be patient-centered rather than health care event centered. The development of an episode profile requires the following steps for construction: 1) create the episode, and 2) construct the expected cost for the episode. Simple to determine quality metrics, such as avoidable admissions, should also be included with the episode if possible. Using established attribution rules, we hope to determine the distribution of CRG episodes for a sample of physicians (using Tax IDs or NPI). The tasks outlined in this contract are exploratory in nature. ■

Evaluation of Competitive Acquisition Program for Part B Drugs

Project No: 500-00-0024/0024
Project Officer: Jesse Levy
Period: September 2005 to January 2010
Funding: $1,305,147.00
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 resulting report to Congress is available at http://cms.hhs.gov/Reports/Downloads/Drozd_CAP_RTC_2009.pdf. A physician survey report is available at http://cms.hhs.gov/Reports/Downloads/Healy_CAP_PhysicianSurveyAnalysis_2009.pdf. The final report is in draft status.

Description: The purpose of this task order 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 Average Sales Price (ASP) payment allowance limit, but instead receives them from a vendor who has won a drug supplier contract through a competitive bidding process. This evaluation examines the range of drugs available to physicians under the CAP, program participation, the effects on Medicare payments, and beneficiary cost-sharing. ■

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

Project No: 500-00-0028/0002
Project Officer: Diane Frankenfield
Period: September 2003 to January 2011
Funding: $1,628,359.00
Principal Investigator: Sylvia Ramirez
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 final Evaluation Report has been finalized and can be found at http://www.cms.gov/Reports/Downloads/Arbor_ESRD_EvalReport_2010.pdf in the CMS website.

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, 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. When the DM sites are selected, the evaluation team will work with them to design and implement data collection instruments and mechanisms. The evaluation contractor will also work with the DM sites to collect and analyze data to measure clinical, quality of life, and economic outcomes. ■

Evaluation of Gainsharing Demonstration

Project No: HHSM-500-2005-00029I/0003
Project Officer: William Buczko
Period: September 2006 to December 2014
Funding: $2,068,665.00
Principal Investigator: Jerry Cromwell
Leslie Greenwald
Award: Contract
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The demonstration began on October 1, 2008. Only Beth Israel NY, is currently participating. The Charleston, WV site ended participation on December 31, 2009. The comparison hospitals for each site have been selected. The first wave of site visits has been completed and reports of each site visit are being written. The documents for the Report to Congress on Quality Improvement and Savings have been submitted to CMS. The Report is due to Congress by March 31, 2011. The baseline data set is being assembled and analysis of baseline characteristics has begun.

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 and to improve the quality and efficiency of care provided to beneficiaries. As specified in the project, methodologies to develop improved operational and financial hospital performance with the sharing of gains will be evaluated. The demonstration requires arrangements between a hospital and the physicians under which the hospital provides for gainsharing payments. These payments

represent a share of the savings incurred directly as a result of collaborative efforts between the hospital and physicians. ■

Evaluation of Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00022I/0001
Project Officer: William Buczko
Period: September 2007 to September 2011
Funding: $447,032.00
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 demonstration began on January 1, 2008. The evaluation contractor has completed the first wave of site visits to nine home health agencies and the first wave of the web survey of participants and has completed the project reports for these activities. The second wave of site visits and the web survey are currently underway. The evaluation contractor has also begun the baseline and Year 1 analyses. The period of performance was extended through September 30, 2011.

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 aims to test the "pay for performance" concept in the HHA setting. Under this demonstration, CMS provides financial incentives to participating HHAs that meet certain standards for providing high quality care. Participation of HHAs in this demonstration is 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 the Outcome and Assessment Information Set (OASIS). This demonstration has selected four states/state groups, one from each region of the U.S.: MA, CT (East), IL (Midwest), CA (West) and GA, AL, TN (South). Within each state/state group, HHAs which elected to participate were randomly assigned to treatment and control groups. The demonstration includes all Medicare beneficiaries that are treated by a participating HHA. Some beneficiaries in the demonstration are also eligible for Medicaid. ■

Evaluation of Low Vision Rehabilitation Demonstration (LVRD)

Project No: 500-00-0031/0006
Project Officer: Pauline Karikari-Martin
Period: September 2005 to August 2010
Funding: $499,582.00
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 final qualitative and quantitative assessment reports are complete. The three reports are posted on the CMS website at: http://www.cms.gov/Reports/Downloads/Leutz_LowVisionProviderReport_2010.pdf http://www.cms.gov/Reports/Downloads/Leutz_LowVisionBeneReport_2010.pdf http://www.cms.gov/Reports/Downloads/Bishop_LowVisiDemoClaims_2010.pdf

Description: This task order is to conduct an evaluation of the Centers for Medicare and Medicaid Services' (CMS') Low Vision Rehabilitation Demonstration (LVRD) to determine the feasibility of expanding specific low vision rehabilitation provider coverage and reimbursements, when considering future payment policy for LVR services. The contractor designed and conducted the evaluation of the demonstration using quantitative and qualitative methods. The qualitative assessments examined issues pertaining to the implementation and operational experiences of the practitioners. Beneficiaries' experiences during the demonstration were also assessed. Data sources include information collected during beneficiary focus groups and provider site visits. The quantitative assessment will use Medicare claims data, to describe the utilization and characteristics of Medicare beneficiaries who used low vision rehabilitation (LVR) services prior to and during the Low Vision Rehabilitation Demonstration period nationally. ■

Evaluation of Medicare Health Care Quality Demonstrations - Phase I

Project No: 500-00-0024/0022
Project Officer: Normandy Brangan
Period: September 2005 to September 2010
Funding: $560,425.00
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: Phase one of this contract will now be considered the complete contract due to delays in the start of the demonstration sites. The no-cost extension expired in September 2010. No further extensions will be considered. The existing contract is being re-scoped to eliminate options and unnecessary tasks and to focus available resources on Task 4.2 in the statement of work, developing case studies of program start up activities, and producing a final case study report to be used in any future evaluation of this demonstration.

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: 500-00-0031/0003
Project Officer: Pauline Karikari-Martin
William Clark
Period: September 2004 to November 2010
Funding: $880,314.00
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 has completed reports on the delivery of integrated care demonstrations and their transition to Medicare Advantage. The contract expired on November 30, 2010.

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: 500-00-0033/0006
Project Officer: Ann Meadow
Period: January 2005 to March 2010
Funding: $639,859.00
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: This project has been completed. The contractor developed a beneficiary survey and conducted site visits and other qualitative data collection. The survey was not administered due to low enrollment in the demonstration. The project plan was modified to address selected research questions, including several that can be answered using information from home health agencies in the demonstration States. Medicare submitted the final Report to Congress in January 2008 (a technical report is available at www.cms.hhs.gov/Reports/downloads/homebound.pdf). The Secretary did not recommend program policy changes, noting that "the complex set of barriers to enrolling beneficiaries . . . are an indication that successful adoption of the eligibility change envisioned in the legislation faces serious impediments." Information from qualitative data collection and the home health agency survey

indicated that barriers included the extensive criteria for enrollment laid out in the legislation, concerns on the part of providers that financing might be inadequate, low interest on the part of beneficiaries in changing their care arrangements, and others. The project also produced an examination of the role of payment outliers in the context of the evaluation findings. To the extent that the characteristics of the demonstration target population and the outlier population overlap, then the demonstration concept may be viable and CMS's outlier policy could play a role in ensuring access to care for this population. Using administrative data, the analysts identified proxy demonstration patients in multiple states, and explored how they compared with patients who qualified for an outlier payment. They found that the proxy demonstration target group is small, and only a small fraction of proxy demonstration patients generate outlier payments, so there is little overlap. Financial outliers include patients with relatively few limitations in functioning, and lower mortality, but they use more home health resources than the proxy demonstration patients. Agencies that serve a disproportionate share of outlier patients had atypical characteristics; they tended to be located in urban areas, to serve relatively few Medicare home health patients, had no association with a hospice, had low costs per visit for nursing and aide services, and generally provided high numbers of such services to their patient caseload overall. Agencies that provided care to a high percentage of proxy demonstration patients differed less noticeably from the general population of HHAs.

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 two 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 three states (representing Northeast, Midwestern, and 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 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 to 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 MMA646 Physician-Hospital Collaboration Demonstration

Project No:	HHSM-500-2005-00029I/HHSM-500-T0001
Project Officer:	William Buczko
Period:	January 2009 to January 2013
Funding:	$1,077,710.00
Principal Investigator:	Leslie Greenwald
Award:	Task Order (MRAD)
Awardee:	Research Triangle Institute, (NC) PO Box 12194, 3040 Cornwallis Road Research Triangle Park, NC 27709-2194

Status: The demonstration began on July 1, 2009. The demonstration facilities and comparison facilities have been selected. Phase 2 has begun and data are being compiled for the baseline period. An interim project report was planned to be available by January 31, 2011.

Description: The evaluation contractor shall develop an evaluation design, assess options for comparison groups, analyze the relevant data, and write evaluation reports as part of the evaluation of the physician-hospital collaboration demonstration project. Work will proceed in two phases. Phase I will include activities related to preparing the evaluation design, terms and conditions of participation, and selection of comparison sites. Phase 2 will continue with the remaining evaluation tasks. ■

Evaluation of MSA Plans Offered under the Medicare Program

Project No: HHSM-500-2006-00009I/0006
Project Officer: Melissa Montgomery
Period: August 2007 to May 2010
Funding: $428,227.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The contract has ended and all reports are posted on the web. The Case Study Report, dated September 2008, can be found at: http://www.cms.hhs.gov/Reports/downloads/Tanamor.pdf. The Focus Group report, dated February 2009 can be found at http://cms.hhs.gov/Reports/Downloads/MSA_Focus_Group_Findings_Report_2009.pdf. The last report, Cross-Cutting Results, dated March 2010 can be found at: http://cms.hhs.gov/Reports/Downloads/Koenig_Cross_Cutting_2010.pdf in the CMS website.

Description: This task order will conduct an evaluation of Medical Savings Account (MSA) plans offered under the Medicare program. MSAs represent an additional choice available to beneficiaries beyond the 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 examine 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: 500-00-0032/0014
Project Officer: Ann Meadow
Period: September 2005 to February 2011
Funding: $2,331,309.00
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: In 2006, survey questionnaires and analysis plans were developed. In 2007, baseline beneficiary and supplier survey work in three sites, as well as site visits, were completed. Also in 2007, a report on early experience under the accreditation program was prepared. In 2008, the contractor delivered a preliminary report on results of site visits they conducted. After a program delay mandated by MIPPA, the contractor collected data to establish a new baseline in mid-2010, including both beneficiary surveys and qualitative information from site visits and interviews. Also, after CMS announced the competitive bidding payment amounts in the first nine metropolitan areas, the contractor analyzed 2009 claims to estimate program savings for the first year of the program, CY2011. The results of all research activities undertaken through Fall 2010 are included in the forthcoming Report to Congress, scheduled for release in mid-2011.

Description: Section 302(b) of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) (MMA) required that in 2007, the Centers for Medicare and Medicaid Services (CMS) begin 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). Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 temporarily delayed and modified the competitive bidding program until 2009. This project's purpose is to provide information for the law's mandated 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 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. Analysis of administrative data will supplement the primary data sources. ■

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

Project No: 500-00-0022/0002
Project Officer: Mary Kapp
Period: September 2004 to September 2010
Funding: $2,668,583.00
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: An initial Report to Congress, issued in June 2007 (www.cms.hhs.gov/Reports/Downloads/McCall.pdf), provides an overview of the scope of the programs, program design and early implementation experience, and preliminary cost and quality findings. A second report to Congress, issued in December 2008 (www.cms.gov/reports/downloads/MHS_Second_Report_to_Congress_October_2008.pdf), provides interim findings on the first 18 months of the pilot programs. The evaluation has been completed and final Phase I results will be presented to Congress in a third report in 2011.

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). These pilot programs have been implemented under the name Medicare Health Support. Eight organizations implemented care management programs in different geographic regions between 2005 and 2008. 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 served as a comparison population. ■

Evaluation of Rural Community Hospital Demonstration

Project No: HHSM-500-2006-00006I/0006
Project Officer: Normandy Brangan
Period: August 2007 to October 2011
Funding: $562,464.00
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The evaluator has prepared case studies of the original nine hospitals enrolled in the demonstration. The Affordable Care Act of 2010 extended the demonstration for another five years, and the Report to Congress continues to be due six months after the end of the demonstration. Because of this change, the evaluation contract was modified to replace the Report to Congress with an Interim Report updating the status of the Rural Community Hospital Demonstration.

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 viability of small rural hospitals. The contractor will also identify strategic and operational challenges faced by the participating hospitals and the impact of demonstration payments on these challenges. CMS will reimburse demonstration hospitals at 100 percent of cost for inpatient care or a target amount, whichever is lower. The impact analysis portion of the evaluation will use the Hospital Cost Reports Information System (HCRIS), the fiscal intermediary or Medicare Administrative Contractor (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 the Cancer Prevention and Treatment Demonstration

Project No: 500-00-0024/0027
Project Officer: Pauline Karikari-Martin
Period: September 2005 to September 2012
Funding: $2,383,994.00
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 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 2007. As of November 25, 2009, there were 10,705 active enrollees in the Cancer Prevention and Treatment Demonstration, with a total of 9,964 in the screening arm and 741 in the treatment arm. Site-specific enrollment numbers are below.

- Utah/Montana: The Huntsman Cancer Institute reported 1,698 initial CSAs completed. Of the CSAs completed, 1,485 are active enrollees and 213 are disenrolled participants. There are currently 1,485 active enrollees that include 571 screening intervention, 870 screening control, 31 treatment intervention, and 13 treatment control. Huntsman conducted 489 annual CSAs and no exit CSAs.
- Baltimore, MD: Johns Hopkins reported completing 2,548 initial CSAs. The completed CSAs include 2,057 active enrollees and 397 disenrollments. The active enrollees include 960 screening intervention, 959 screening control, 67 treatment intervention, and 71 treatment control. Hopkins conducted 1,120 annual CSAs and 100 exit CSAs.
- Hawaii: Moloka'i General Hospital reported that they have completed 449 initial CSAs. The completed CSAs include 382 active enrollees and 57 disenrollments. The active enrollees include 174 screening intervention, 186 screening control, 15 treatment intervention, and 7 treatment control. Moloka'i completed 196 annual CSAs and 179 exit CSAs.
- Detroit, MI: Josephine Ford reported 5,579 initial CSAs completed. Of the completed initial CSAs, 4,068 are active enrollees and 1,511 are disenrolled participants. The active enrollees include 1,762 screening intervention, 2,027 screening control, 133 treatment intervention, and 146 treatment control. Ford completed 1,661 annual CSAs and 503 exit CSAs.
- Newark, NJ: UMDNJ reported 1,108 initial CSAs completed. The completed initial CSAs include 931 active enrollees and 177 disenrollments. The active enrollees include 873 participants in the screening group and 58 in the treatment group. UMDNJ have completed 373 annual CSAs.
- Houston, TX: M.D. Anderson Cancer Center reported 2,059 initial CSAs completed. The completed initial CSAs include 1,782 active enrollees and 277 disenrollments. MDACC's active enrollees include 757 screening intervention, 825 screening control, 101 treatment intervention, and 99 treatment control.

The evaluation is well underway. The first Report to Congress was completed in advance of the September 2008 deadline and was been signed by Secretary Leavitt. The second Report to Congress was completed in December 2010. A final report will be completed by September 2012.

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. This comparison will be accomplished by addressing such issues as the elimination or reduction of disparities in cancer screening rates, timely facilitation of diagnostic testing, timely facilitation of appropriate treatment 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 rural Utah/Montana). The task order contract is 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 Four is currently funded. ■

Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare

Project No: 500-00-0031/0007
Project Officer: Carol Magee
Period: September 2005 to June 2010
Funding: $1,553,273.00
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: 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 four demonstration regions was put into the six 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 four control regions and for the analysis of Medicare Claims data. The final phase (Phase Two) has been extended nine months, until June 30, 2010. An interim, letter-format Report to Congress, covering the initial 18 of the 24 months of the demonstration, was sent to Congress in October 2008. A separate report on Budget Neutrality was provided in winter 2009. The Final Report to Congress, covering the full 24 months of demonstration claims, was sent in January 2010. This Evaluation contract ended on June 30, 2010. Summary of findings: The demonstration had a slow ramp-up in year one due to billing system difficulties, with improvement in year two. Overall, only 40% of eligible chiropractors participated. Surveyed beneficiaries were highly satisfied with services and reported good symptom relief. Almost 70% had additional insurance that covered some chiropractic care. Among users of any expanded care, chiropractic visits increased by 60% overall, and Medicare costs related to expanded services increased by $34.8 million. Budget neutrality analysis showed that, among users of any chiropractic services for neuromusculoskeletal conditions, total Medicare costs increased by $50 million overall for the expanded care regions, when compared to standard chiropractic users' total Medicare costs in matched control counties. Nearly all of the increased costs occurred in urban non-HPSA areas and in Chicago, Illinois and suburbs. WEB URL: http://www.cms.hhs.gov/Reports/Downloads/Stason_Chiro_RTC_2010.pdf.

Description: This Task Order was to assess the feasibility and advisability of expanding the coverage of chiropractic services under the Medicare program. The evaluation was 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 paid by the Medicare program, than do comparison beneficiaries with approved neuromusculoskeletal (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 reimbursable chiropractic services in the treatment regions;
4) Determine the quality of 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. ■

Evaluation of the Electronic Health Records Demonstration

Project No: HHSM-500-2005-00025I/0006
Project Officer: Lorraine Johnson
Period: March 2008 to March 2016
Funding: $5,225,643.00
Principal Investigator: Lorenzo Moreno
Sue Felt-Lisk
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The first year OSS has been completed. Initial round of site visits was completed. The implementation report is in the review process.

Description: This task order will evaluate the effectiveness of the Electronic Health Record (EHR) Demonstration authorized under Section 402 Medicare Waiver Authority. The goal of this five-year pay for performance demonstration is to promote high quality care through the adoption and use of health information technology/electronic health records. The target population for the demonstration is primary care physicians in small to medium-size practices, in four sites, that provide primary care to Medicare FFS beneficiaries with Diabetes, Coronary Artery Disease, Congestive Heart Failure, and other chronic diseases. The demonstration began in June 2009. ■

Evaluation of the Extended Medicare Care Management for High-Cost Beneficiaries Demonstration

Project No: HHSM-500-2005-00029I/HHSM-500-T0002
Project Officer: Lorraine Johnson
Period: April 2009 to April 2013
Funding: $692,430.00
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: The evaluation is active and on schedule. Three sites were given an extension (Phase 2). One site requested and was granted approval for expansion to one other site; another requested and was granted approval to expand to two sites. Final evaluation reports for Phase 1 are in process of being finalized. Creation of Phase 2 comparison groups are completed. The first round of Phase 2 site visits have been completed with plans for second round are in process.

Description: The Care Management for High Cost Beneficiaries (CMHCB) Demonstration, started in October 2005, provided disease management services for thousands of beneficiaries. The Centers for Medicare & Medicaid Services (CMS) awarded six organizations a three year demonstration project. The principal objective of this demonstration was to test a pay-for-performance contracting model and new intervention strategies for Medicare fee-for-service (FFS) beneficiaries, who are high-cost and who have complex chronic conditions; with the goals of reducing future costs, improving quality of care and quality of life, and improving beneficiary and provider satisfaction. CMS extended three of the original six demonstrations which showed sufficient promise of quality improvement and cost savings, under authority provided in Section 402 of Public Law 92-603 for a maximum of three years with annual renewals subject to quarterly financial evaluation of performance. This task order continues to study the design and implementation of the three extended programs and to evaluate the experience of the intervention group on 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, promote efficient use of health care services, and produce savings for Medicare in the intervention group. Under this contract the evaluator assisted CMS with the design features

of the extended and expanded programs to assure that suitable control groups were identified. The evaluator also revised the design of the original evaluation plan to account for lessons learned in the execution of the original evaluation. ■

Evaluation of the Extended Medicare Coordinated Care Demonstration

Project No: HHSM-500-2005-00025I/0012
Project Officer: Carol Magee
Period: September 2008 to September 2011
Funding: $599,688.00
Principal Investigator: Deborah Peikes
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Fourth Report to Congress (RTC) was entered in the CMS/HHS circulation review process during October 2009 and is still in the circulation process at HHS. Since the demonstration is ongoing, until June 2013, there will be a Fifth RTC, due to Congress in April 2012. That Fifth RTC draft will be submitted into formal circulation review in fall of 2011. Among the final two MCCD programs that had continued into 2010, only one (Health Quality Partners (HQP), of PA.) has continued to operate. HQP requested and received an approved extension for three years, until June 2013. HQP's care model has been refined to focus on the more successful elements of their prior intervention, and to be restricted to high-risk categories of patients (with selected cardiovascular, pulmonary, and diabetic conditions) who have shown the significant benefit from their program.

Description: The purpose of this task order is to have one of CMS's existing Medicare Research and Demonstration (MRAD) Task Order contractors conduct the extended evaluation of the Medicare Coordinated Care Demonstration (MCCD). The MCCD, which began in 2002, will be evaluated for those programs which were extended beyond the initial four year period of operations (i.e., 2002 - 2006) and for which findings were just reported in the third Report to Congress (RTC). Eleven of the programs were extended up through a sixth year (2008). While eight of the 11 programs lacked evidence of cost-effectiveness after their initial four years of operation and ended in 2008, two of the other three programs have now been extended two more years, into spring of 2010. This task order will provide the cumulative evaluation of these eleven extended programs. There will be two major deliverables. The final fourth RTC will focus solely upon the two more successful programs that were extended until 2010, and will cover cumulative claims coverage from 2002 up through September 30, 2008. In addition, it will provide an assessment of interventions and characteristics within and/or across the two programs that appear to be associated with successful quality or cost outcomes. A subsequent final report to CMS will encompass the total, cumulative claims analyses for each of these 11 extended MCCD programs, from 2002 until their respective closure dates. The evaluation contract period of performance will run for 36 months, from September 2008 through September 2011. This evaluation of the cumulative experience for each of the 11 extended MCCD programs will provide Congress and CMS with information that is important and relevant for future decisions regarding the cost-effectiveness and health outcomes of care coordination and disease management within the Medicare Fee-for-Service (FFS) milieu. Furthermore, the identification of any association of program characteristics or intervention process components with their quality of care and/or cost outcomes within the two more successful extended programs may delineate more specific models of care management success that can be tested in the future. ■

Evaluation of the LifeMasters Disease Management Demonstration Program for Dual Eligible Beneficiaries

Project No: HHSM-500-2005-00025I/0011
Project Officer: Lorraine Johnson
Period: August 2008 to November 2010
Funding: $120,699.00
Principal Investigator: Dominick Esposito
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The evaluation report for the first three years has been completed and is available on the CMS Web site. The LifeMasters demonstration program ended prematurely on August 31, 2009 because it had not shown any significant trend toward achieving budget neutrality over the remaining demonstration period. The final evaluation report has been completed. Contract period of performance ended on November 30, 2010.

Description: The LifeMasters fee-for-service population-based disease management demonstration was authorized by Section 402(a)(1)(B) of Public Law 90-248, as amended (42 U.S.C. 1395b-1(a)(1)(b)). LifeMasters provides disease management services to chronically ill dual-eligible fee-for-service Medicare beneficiaries in the state of Florida. The targeted conditions are congestive heart failure (CH), coronary artery disease (CAD), and diabetes. The goal of the program is to increase quality of care and reduce Medicare costs. The program is required to be budget neutral. The demonstration began January 1, 2005 and was scheduled to end December 31, 2007. CMS extended the LifeMasters program demonstration for an additional three years because it was beginning to show some Medicare cost savings. The demonstration extension period was January 1, 2008 - December 31, 2010. For the extension, the evaluation contractor was required to submit an interim summary report and a final report to CMS based on claims analysis. The reports included examining the effects of the demonstration on quality-of-care processes, Medicare service utilization, and Medicare costs. ■

Evaluation of the Medical Adult Day-Care Services Demonstration

Project No: 500-00-0031/0005
Project Officer: Susan Radke
Period: September 2005 to November 2010
Funding: $821,916.00
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 completed all phases of the evaluation. The Report to Congress was sent to Congress and the Final Report is completed.

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 lasted 18 months and included finalization of the evaluation plan, most of the qualitative analyses, and preliminary activities related to the quantitative analysis. Phase 2 followed immediately after Phase 1 and lasted for 30 months. The bulk of the quantitative analysis was completed during Phase 2, and the final report was delivered to CMS Finally, Phase 3 consisted of an optional, extended period of 12 months, during which the contractor made revisions to the Report to Congress, as required during the federal review process, and address inquiries as needed. ■

Evaluation of the Medicare Acute Care Episode (ACE) Demonstration

Project No: HHSM-500-2006-00007I/HHSM-500-T0001
Project Officer: Jesse Levy
Period: June 2009 to June 2014
Funding: $777,443.00
Principal Investigator: Osaldo Urdapilleta
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: The analysis plan was delivered. The first year report was due in December, 2010.

Description: The purpose of this task order is to design and conduct an evaluation of the Medicare ACE demonstration. The contractor will be responsible for collection of selected data and analysis of both primary data collected via interviews, focus groups, and/or surveys, and secondary data from Medicare claims, CMS administrative data, and secondary survey or market data. The contractor will be responsible for determining the appropriate comparison populations or other methods for evaluating outcomes and budget neutrality, as well as assessing shared savings, as addressed in the MMA legislation. ■

Evaluation of the Medicare Care Management Performance Demonstration

Project No: HHSM-500-2005-00025I/HHSM-500-T0001
Project Officer: Lorraine Johnson
Period: September 2009 to December 2011
Funding: $1,084,309.00
Principal Investigator: Lorenzo Moreno
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The demonstration ended on June 30, 2010. The Report to Congress has been submitted to CMS and covers the first two years of this three-year demonstration. The final evaluation report due December 20, 2011 will cover all three years. The beneficiary and physician surveys and office system surveys have been completed. The interin evaluation report and second round of site visits have been completed. The final implementation report and the Report to Congress are in the review process.

Description: Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Secretary of Health and Human Services to conduct the Medicare Care Management Performance (MCMP) demonstration. MCMP is a three year pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology (HIT) and evidence-based guidelines for promoting continuity of care, helping stabilize conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions due to polypharmacy. The target population for the demonstration consists of primary care physician practices with ten or fewer physicians, in up to four states, who treat FFS Medicare beneficiaries with diabetes, heart conditions, and/or other chronic conditions. The MCMP evaluation tasks include a comprehensive case study component to examine issues pertaining to the implementation and operational experiences of the participating practices, and an examination of the effect of financial incentives and use of HIT on care management, quality of care, and impacts on the use and costs of services. ■

Evaluation of the Medicare Care Management Performance Demonstration

Project No: 500-00-0033/0005
Project Officer: Lorraine Johnson
Period: September 2004 to December 2011
Funding: $1,707,028.00
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 under this contract has been extended to Decemeber 31, 2011. The implementation report is completed and posted on the CMS website. Beneficiary and physician surveys have been completed. The office systems survey has been completed. Interim evaluation report has been completed.

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

Evaluation of the Medicare Imaging Demonstration Project

Project No: HHSM-500-2005-00028I/HHSM-500-T0003
Project Officer: David Nyweide
Period: September 2010 to June 2014
Funding: $2,234,407.00
Principal Investigator: Katherine Kahn
Peter Hussey
Award: Task Order (MRAD)

Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The project Design Report is in progress as preparation begins for demonstration implementation.

Description: As part of the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275), Section 135(b) stipulates that the Secretary of Health and Human Services design, implement, manage, and evaluate a demonstration project to assess the appropriateness of advanced diagnostic imaging procedures in the fee-for-service Medicare program. Through the use of decision support systems (DSSs), the demonstration project seeks to quantify rates of inappropriate advanced image ordering and to determine whether exposing physicians to professional guidelines when ordering advanced imaging procedures is associated with more appropriate ordering and a reduction in utilization. The Medicare Imaging Demonstration (MID) aims to recruit up to 5,000 physicians to participate in the two year demonstration, slated to begin in January 2011. All physicians in a practice will consult a DSS whenever they intend to order any 1 of 11 advanced imaging procedures involving diagnostic magnetic resonance imaging (MRI), computed tomography (CT), or Single Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI). Based on appropriateness guidelines written by medical specialty societies, the DSS will rate the appropriateness of the order and inform the ordering physician. The physician, though, retains the autonomy to order any imaging procedure deemed necessary; prior authorization is prohibited by statute. The primary purpose of this task order is to evaluate the MID. ■

Evaluation of the Medicare Medical Home Demonstration

Project No: HHSM-500-2005-00029I/0016
Project Officer: Suzanne Goodwin
Mary Kapp
Period: September 2008 to September 2013
Funding: $2,971,101.00
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: The demonstration had been scheduled to begin January 1, 2010, but has been delayed.

Description: The purpose of this project is to design and conduct an evaluation of the Medicare Medical Home Demonstration. The three year project is authorized by Section 204 of the Tax Relief and Health Care Act of 2006 and amended by Section 133 of the Medicare Improvements for Patients and Providers Act of 2008. The demonstration will "provide targeted, accessible, continuous, and coordinated family-centered care to high needs populations." Under this demonstration, personal physicians will receive a monthly management fee payment for each Medicare beneficiary enrolled in the medical home demonstration. The demonstration will be conducted in a mix of large and small practices in up to eight states. The evaluation will identify key features of practices providing medical home services to Medicare beneficiaries. The findings from the analyses will be used to prepare the annual Reports to Congress as directed by the legislation. ■

Evaluation of the Nursing Home Value Based Purchasing Demonstration

Project No: HHSM-500-2006-00009I/0007
Project Officer: William Buczko
Period: September 2008 to September 2012
Funding: $699,807.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project kickoff meeting was held on September 22, 2008. The project evaluation plan was submitted to CMS in December of 2008. The evaluation team is creating analytic files from MDS data and will be requesting claims data for residents of the facilities in the treatment and comparison groups. The discussions with stakeholder groups and site visits have been completed. The first year (background) report was submitted on July 12, 2010. File building for the baseline period has begun.

Description: The Nursing Home Value Based Purchasing (NHVBP) demonstration is part of a CMS initiative to improve the quality of care furnished to Medicare beneficiaries in nursing homes. This demonstration will test the "pay for performance" concept applied to the nursing home setting prior to implementing NHVBP nationally. CMS will provide financial incentives to participating nursing homes that meet certain standards for providing high quality care. CMS will assess the performance of participating nursing homes based on selected measures of quality of care, then make payment awards to those nursing homes that achieve a high level of performance or exceptional improvement based on those measures. Domains represented in the quality measures including staffing, appropriate hospitalizations, outcome measures from the minimum data set (MDS), and inspection survey deficiencies. CMS will award points to each nursing home based on how they perform on the measures within each of the domains. These points will be summed to produce an overall quality score. In addition, CMS will compare certain risk-adjusted Medicare Part A, B, and D (if available) payments per resident between the experimental and control groups to determine if there are savings to Medicare. ■

Evaluation of the Part D Payment Demonstration

Project No: 500-00-0024/0023
Project Officer: Aman Bhandari
Period: September 2005 to August 2010
Funding: $1,015,315.00
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: All reports from this evaluation have been completed, including the Medicare Part D Payment Demonstration Site Visit Report and the Medicare Part D Payment Demonstration Focus Group Report and the Final Summary Report. The evaluation reports have been posted on the CMS Web site or are available via request. The Final Summary Report was completed as of summer 2010 and along with the end of the evaluation.

Description: This project focused on evaluating the impact of the Medicare Part D payment "reinsurance" demonstration. CMS has announced its intent to conduct a demonstration that represented an alternative payment approach for private plans offering prescription drug coverage under Part D. The demonstration was 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 examined the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs), and Medicare program costs. From the beneficiary perspective, the evaluation focused 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 explored the advantages and disadvantages of participation from the perspective of drug plan sponsors and the Medicare program. Both primary (site visits, focus groups) and secondary CMS data sources were used in the evaluation of this demonstration. ■

Evaluation of the Premier Hospital Quality Incentive Demonstration

Project No: HHSM-500-2005-00029I/HHSM-500-T0003
Project Officer: Linda Radey
Period: July 2009 to July 2012
Funding: $508,525.00
Principal Investigator: Shulamit Bernard
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 now in Phase II. This project also includes an 18-month option after the end date.

Description: The purpose of this project is to evaluate the impact of the six years of the Premier Hospital Quality Incentive Demonstration (PHQID) on the changes in the quality of hospital care, the impacts on Medicare beneficiary acute-care inpatient length of stay (LOS), and mortality for six prevalent inpatient diagnoses. Premier enrolled 250 hospitals (with 230 Medicare provider numbers) that also participated in the first three years of the demonstration. These hospitals belong to a group of over 500 hospitals that subscribe to Premier's Perspectives hospital management system. Under the first three years of the demonstration, CMS

rewarded top-performing hospitals in each year of the demonstration. In addition, CMS penalized hospitals in the third year of the demonstration that performed below an absolute level of quality that was established after the first year of the demonstration. The extension includes a sixth clinical area, Surgical Care Improvement Project (SCIP). CMS also added test measures. Under the extension, CMS revised the incentive structure to reward not only top performers, but also those that attain median quality and those that improve the most. Penalties were also imposed on hospitals with low composite scores on the quality measures during the extension. ■

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

Project No: 500-00-0033/0001
Project Officer: Fred Thomas
Period: September 2001 to December 2009
Funding: $2,469,794.00
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 complete and the Report to Congress was authorized and published in January, 2009 by the Department of Health and Human Services. The Report to Congress is available at: http://www.cms.hhs.gov/PACE/Downloads/Report%20to%20Congress.pdf. Supporting reports include: "The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality" (available at http://www.cms.hhs.gov/reports/downloads/Beauchamp_2008.pdf) and "The Effects of PACE on Medicare and Medicaid Expenditures" (available at http://www.cms.hhs.gov/reports/downloads/Foster_PACE_2009.pdf). The BBA mandated report on the for-profit PACE demonstration is not feasible as of December 31, 2009 because the two for-profit demonstration sites have not existed long enough to be evaluated. A supplemental report on a community-based practice model named, "How Integrated Care Programs Use Community-Based, Primary Care Physicians" has been completed 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: 500-00-0026/0004
Project Officer: Linda Radey
Period: September 2005 to December 2010
Funding: $832,051.00
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 and is in its second phase. 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. The Report to Congress is under review.

Description: The purpose of this project is to evaluate the impact of the Rural Hospice Demonstration on changes in the hospice utilization and benefits to the community 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. For one of the hospices in the demonstration, CMS will also waive the 20-percent inpatient day cap and the requirement that the hospice must provide care in the community. Evaluation tasks include monitoring the progress of the demonstration and the preparation of case studies and impact analyses using secondary data. Evaluation results will be incorporated into a Report to Congress when the demonstration ends. ■

Evaluation of the Senior Risk Reduction Program

Project No: HHSM-500-2006-00007I/0007
Project Officer: Pauline Karikari-Martin
Period: September 2008 to September 2013
Funding: $199,955.00
Principal Investigator: Daver Kahvecioglu
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: This task was awarded to the XRAD contractor IMPAQ in September of 2008. All initial site visit reports have been completed. The overall project is in progress.

Description: The purpose of this Task Order is to evaluate the effectiveness of the Senior Risk Reduction Demonstration (SRRD) in health promotion, health management, and disease prevention. The objectives of the SSRD interventions are to improve the health and well-being of Medicare beneficiaries and to reduce beneficiary expenditures under Part A and B of the Medicare program. Participants in SRRD are non-institutionalized Medicare fee-for-service beneficiaries enrolled in Medicare Parts A and B and between the ages of 67 and 74. Demonstration vendors will provide risk reduction services to randomly selected beneficiaries nationwide (SRRD-N) and from communities which have exemplary Information and Referral/Assistance (SRRD-Local) programs for seniors. The contractor will be required to design and conduct the evaluation of this demonstration, which will inform CMS on the reduction in selected health risks among Medicare beneficiaries using secondary data from the Health Risk Appraisal (HRA) surveys, and budget neutrality of the demonstration costs using CMS Medicare claims data. ■

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: $ 1,000.00
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 and is in its fifth year. Currently there are nine 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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: $ 1,000.00
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 and is in its third year. Currently, there are twenty 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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: $ 1,000.00
Principal Investigator: Sharon Benus
Award: Task Order Contract, Base
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: This is an umbrella contract and is in its fifth year. Currently there are seventeen 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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: $ 1,000.00
Principal Investigator: David Kennell
Award: Task Order Contract, Base
Awardee: Kennell and Associates, Inc.
3130 Fairview Park Drive, Suite 505
Falls Church,VA 22042

Status: This is an umbrella contract and is in its fifth year. Currently there are five 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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: $ 1,000.00
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 and is in its fifth year. Currently there are twelve 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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: $ 1,000.00
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 and is in its fifth year. Currently there is one 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 research and development activities. These projects will relate to Medicare, Medicaid, and the Children's Health Insurance Program (MM/CHIP) 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/0009
Project Officer: Kathryn Poisal
Period: September 2007 to September 2011
Funding: $692,019.00
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contract was recently modified so that the funding was increased and the period of performance was extended. The project is on schedule.

Description: Self-direction continues to grow in numerous ways. This is evidenced by the number of waivers offering self-direction, the number of individuals who may avail themselves of self-direction, and the 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 the 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 order will provide states with individual technical assistance and information to determine the vehicle that will best 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 conform to all applicable federal and state guidelines. The contractor, through the scenarios encountered during state specific technical assistance activities, will identify areas requiring systematic 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. ■

Federally Qualified Health Center/Advanced Primary Care Practice Demonstration Implementation

Project No: HHSM-500-2005-00026I/HHSM-500-T0003
Project Officer: James Coan
Period: September 2010 to August 2014
Funding: $824,740.00
Principal Investigator: Mahil Senathirajah
Award: Task Order
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: The project is underway.

Description: The purpose of this effort is to assist the Medicare Demonstrations Program Group at the Centers for Medicare & Medicaid Services (CMS) in recruitment, processing applications, and monitoring practice changes for the Federally Qualified Health Center Advanced Primary Care Practice Demonstration (FQHC/APCP). The demonstration will evaluate the impact of the advanced primary care practice model on the cost, quality, and accessibility of care provided to Medicare beneficiaries served by Federally Qualified Health Centers (FQHCs). The advanced primary care practice model is also referred to as the patient-centered medical home (PCMH). CMS anticipates recruiting up to 500 FQHCs for the three year demonstration. A contractor is needed to provide assistance to CMS in recruiting participants and processing the large number of applications that are expected, which will facilitate the timely implementation of the demonstration. In addition, CMS requires a contractor to monitor changes in participating medical practices. ■

Florida Family Planning Waiver

Project No: 11-W-00135/04
Project Officer: Rebecca Burch Mack
Period: August 1998 to January 2011
Funding: $ 0.00
Principal Investigator: Elizabeth Dudek
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: On October 8, 2009, the State requested a three year extension of the Demonstration; the request is pending. The Demonstration is currently operating under a temporary extension that was set to expire on January 31, 2011. Approximately 50,000 individuals were enrolled in the Demonstration.

Description: This demonstration provides coverage for family planning services to all uninsured women age 14 through 55 with income at or below 185% FPL who are not otherwise eligible for Medicaid, SCHIP or Medicare, and who have lost Medicaid eligibility within the last two years. ■

Florida Medicaid Reform

Project No: 11-W-00206/04
Project Officer: Mark Pahl
Period: October 2005 to June 2011
Funding: $ 0.00
Principal Investigator: Elizabeth Dudek
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: The demonstration is currently is operating in five counties (Broward, Duval, Baker, Clay and Nassau). As of June 30, 2010, 287,453 individuals were enrolled in the demonstration. On June 30, 2010, the State requested to renew the demonstration, which is scheduled to expire June 30, 2011. The State's request is under review. On January 29, 2010, the demonstration was amended to uncouple the previous statewide expansion requirement from access to Low Income Pool funds.

Description: Under the Florida Medicaid Reform demonstration participation in managed care 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 (LIP) 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. ■

Florida MEDS-AD

Project No: 11-W-00205/04
Project Officer: Mark Pahl
Period: December 2005 to December 2013
Funding: $ 0.00
Principal Investigator: Elizabeth Dudek
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: As of June 30, 2010, 33,980 individuals were enrolled in the demonstration. On July 15, 2010, the demonstration was amended to permit the State to receive FFP for data mining activities performed by the State's Medicaid Fraud Control Unit. On December 14, 2010, CMS approved an extension for this demonstration through December 31, 2013.

Description: The Florida MEDS-AD demonstration provides coverage for certain aged and disabled individuals with incomes up to 88% 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 certain individuals. The demonstration will be funded through savings generated from avoiding high cost institutional placement that would occur in the absence of the pharmacy case management services. ■

Frontier Extended Stay Clinic Demonstration

Project No: ORDI-10-0001
Project Officer: Siddhartha Mazumdar
Period: April 2010 to April 2015
Funding: $ 0.00
Award: Waiver-Only Project

Status: The project is underway. There are currently four clinics certified to process Medicare claims under the demonstration: - Alicia Roberts Medical Center,

Prince of Wales Island, Alaska - Haines Health Center, Haines, Alaska - Iliuliuk Family & Health Services, Unalaska, Alaska - Inter Island Medical Center, Friday Harbor, Washington

Description: The Frontier Extended Stay Clinic (FESC) demonstration, allows remote clinics to treat patients for more extended periods than are entailed in routine physician visits, including overnight stays. According to the legislation, a clinic must be located in a community that is at least 75 miles from the nearest acute care hospital or critical access hospital, or that is inaccessible by public road. The law mandates that the project last for three years. The law allows waiver of provisions of the Medicare program as are necessary to conduct the demonstration project. The FESC will address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who need monitoring and observation for a limited period of time, but do not require hospitalization. Conditions of participation developed for the demonstration identify the criteria by which patients would be eligible for FESC services, what practitioners are eligible to participate in the treatment of an extended stay patient and how soon they must arrive at the facility, specific life safety requirements, and other types of rules that govern providers. ■

Geographic Variation in Prescription Drug Spending

Project No: HHSM-500-2006-00006I/0002
Project Officer: Jesse Levy
Period: August 2006 to January 2010
Funding: $185,971.00
Principal Investigator: Grecia Marrufo
Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The Report to Congress has been delivered and is available on CMS' website here: http://cms.hhs.gov/Reports/Downloads/MaCurdy_RxGeoPrice_RTC_2009.pdf. The final report from the project is available here: http://www.cms.hhs.gov/Reports/Downloads/MaCurdy_RxGeoPrice_TechReport_2009.pdf. All tasks from the project are complete.

Description: This Task Order, mandated under Section 107(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) analyzes 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 analyzes the impact of a geographic adjuster on Medicare's direct subsidies to Part D plans, if wide geographic variations are found. ■

Georgia Planning for Healthy Babies (P4HB)

Project No: 11-W-00249/04
Project Officer: Juliana Sharp
Period: October 2010 to December 2013
Funding: $ 0.00
Principal Investigator: Jerry Dubberly
Award: Waiver-Only Project
Awardee: Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Status: The Demonstration was approved on October 29, 2010 and was expected to be implemented on January 1, 2011.

Description: This Demonstration provides family planning and family planning-related services to uninsured women, ages 18 through 44, who have family income at or below 200% FPL, and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program. The Demonstration also provides interpregnancy care services to women, ages 18 through 44, who have family income at or below 200% FPL, and who delivered a very low birth weight baby on or after January 1, 2011. ■

Hawaii QUEST Expanded

Project No: 11-W-00001/09
Project Officer: Jessica Schubel
Period: July 1993 to June 2013
Funding: $ 0.00
Principal Investigator: Kenneth Fink
Award: Waiver-Only Project
Awardee: Department of Human Services
P. O. Box 70019
Kapolei, HI 96709-0190

Status: On May 1, 2010, CMS approved the State's request to include a temporary program designed to boost employment and increase health coverage for low income individuals and their families during the economic recession that is affecting Hawaii. The amendment will provide a 12 month subsidy for employers who hire new employees with household income up to and including 400% FPL, and provide them with employer sponsored insurance (ESI). The program will be known as the "Hawaii Premium Plus (HPP) program."

Description: Hawaii's QUEST program is a statewide program, and provides medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program. The QUEST program covers adults with incomes at or below 100% FPL and uninsured children with family incomes at or below 200% FPL. In addition, the QUEST-Net program provides a full Medicaid benefit for children with family incomes above 200, but not exceeding 300% FPL and a limited benefit package for adults with incomes at or below 200% FPL who were previously enrolled under the QUEST program. The QUEST-ACE component provides the same benefits as QUEST-Net component to adults with incomes up to 200% FPL who are not eligible under the State Plan or cannot enroll into QUEST due to the enrollment cap. The Quest Expanded Access (QExA) program provides long term care services for the aged, blind and disabled (ABD) populations using an integrated managed care delivery system. In May 2010, the Demonstration was amended to include the Hawaii Premium Payment Program which provides a 12 month subsidy to eligible employers for providing employer-sponsored health insurance to qualified employees, with a date of hire, beginning May 1, 2010 up to April 30, 2011. ■

Hawaii Rural Health Interdisciplinary Training Demonstration Project

Project No: 144514
Project Officer: James Coan
Period: July 2006 to December 2009
Funding: $990,000.00
Principal Investigator: Ronald Schurra
Award: Grant
Awardee: Hawaii Health Systems Corporation
3675 Kilauea Avenue
Honolulu, HI 96818

Status: This grant expired on December 31, 2009. There are currently no plans to extend this grant.

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. The project and training are paired with the 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 health care providers are clustered around tertiary care hospitals in Honolulu. Likewise, medical education and health professional training sites 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 state and federal governments in the future. This project relies on the development of a partnership between the Hilo Medical Center, community, and the University of Hawaii Department of Family Medicine and Community Health. Together 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. ■

Health Advocacy Workshop for Westchester County Seniors

Project No: 1C0CMS030442/01
Project Officer: Benjamin Howell
Period: August 2009 to January 2011
Funding: $ 95,000.00
Principal Investigator: Deborah Dinkelacker
Rachel Bennett
Award: Grant
Awardee: Medicare Rights Center, Inc.
520 Eighth Avenue
New York, NY 10018

Status: The Medicare Rights Center is currently working on this project. A final report on their work is due in January 2011.

Description: The goal of this program is to increase community vitality, improve individual health, and result in the reduction of health expenditures for county seniors and possibly for New York State. The Medicare Rights Center seeks to accomplish this via a health advocacy program consisting of a series of volunteer-led workshops that will help Medicare beneficiaries navigate the health care system. ■

Health Care for Kids (HCFK)Program

Project No: 1C0CMS330727-01-00
Project Officer: Pauline Karikari-Martin
Period: June 2010 to May 2011
Funding: $200,000.00
Principal Investigator: Barry Fisher
Award: Grant
Awardee: County of Ventura
800 S. Victoria Ave
Ventura, CA 93009

Status: This project is underway.

Description: The goal of this project is to increase health care coverage among eligible but unenrolled children residing in Ventura County, California. ■

Health Reform Dashboard

Project No: HHSM-500-2010-000011/HHSM-500-T0004
Project Officer: James Beyer
Period: July 2010 to January 2011
Funding: $4,294,271.00
Principal Investigator: Tim Rowe
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: The project is underway. The management of the project was moved to the Department of Health and Human Services.

Description: The Center for Innovation and Strategic Planning is responsible for the development of a web portal for the tracking and monitoring of activities, milestones, and results from the implementation of Health Reform legislation. The web portal will serve as a resource that will allow Health and Human Services (HHS) senior management, White House staff members, and other authorized users to easily monitor the progress being made and the performance results from implementation of health reform. The initial release of the health reform dashboard will focus on metrics for the first four major reform provisions to go live: 1) High Risk Pool; 2) Early retiree Reinsurance; 3) The Health Insurance Options Website; and 4) Health Insurance Reform. The primary emphasis of the contract will be to: 1) Develop a list of recommended performance metrics, metric algorithms, and data sources to track the implementation and outcomes of health reform program initiatives and policy changes; 2) Develop a web portal that will provide (1) a mechanism for structured user data input; (2) health reform data management resources and services and program implementation progress; and (3) status reporting on project and initiatives implemented as part of health reform; 3) Develop a list of recommendations for budgeting, implementation, and management of the health reform dashboard and the decision support system. ■

Healthier Mississippi

Project No: 11-W-00185/04
Project Officer: Mark Pahl
Period: September 2004 to December 2013
Funding: $ 0.00
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: As of June 30, 2010, 5,000 individuals were enrolled in the demonstration. On October 28, 2010, the demonstration was renewed through December 31, 2013.

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. ■

Healthy Indiana Plan (HIP)

Project No: 11-W-00237/05
Project Officer: Juliana Sharp
Period: December 2007 to December 2012
Funding: $ 0.00
Principal Investigator: Patricia Cassanova
Award: Waiver-Only Project
Awardee: Office of Medicaid Policy and Planning, Family and Social Services Administration
402 W. Washington Street Room W382
Indianapolis, IN 46204-2739

Status: On January 29, 2010, the State received approval of an amendment that added two new projects to the list of required cost-savings projects, raised the limit on nursing facility care in the HIP benefit from 30 to 60 days, changed how the State's DSH allotment is allocated between demonstration expenditures and payments to hospitals, changed eligibility parameters for the Enhanced Services Plan, and raised the member enrollment cap on HIP childless adults from 34,000 to 36,500. The Demonstration is scheduled to expire on December 31, 2012. As of October 31, 2010, there were 42,873 individuals enrolled in the Demonstration.

Description: The Healthy Indiana Plan Demonstration provides health insurance coverage (HIP coverage) to uninsured adults with family incomes up to 200% FPL. HIP coverage is available to custodial parents of Medicaid and Children's Health Insurance Program (CHIP) children who are not themselves eligible for Medicaid, and childless adults. HIP coverage consists of a high-deductible health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account. Persons who elect to participate in HIP coverage must make a monthly contribution to their POWER Account, which is determined on a sliding scale based on income. Persons who drop HIP coverage are refunded at least a portion of their unused contributions. In addition to providing HIP coverage, the Demonstration also provides mandatory capitated managed care benefits to Medicaid eligible parents, caretaker relatives, children, and pregnant women through the Hoosier Healthwise program. Funding for the expanded coverage comes from a reduction in total payment adjustments to disproportionate share hospitals (DSH), and from anticipated savings from the families with children and pregnant women populations. In addition to expanding coverage, the State hopes to encourage newly covered individuals to stay healthy and seek preventative care, give them greater control of their health care decisions and incentivize positive health behaviors, make individuals aware of the cost of health care services, and encourage provision of quality medical services. ■

Helping Obtain Medicaid Essential Services (HOMES)

Project No: 1C0CMS030448/01
Project Officer: Pauline Karikari-Martin
Period: August 2009 to January 2011
Funding: $ 95,000.00
Principal Investigator: Virginia Knowlton
Award: Grant

Awardee: Maryland Disability Law Center
1800 N. Charles Street
Baltimore, MD 21201

Status: The grant project is in progress and on schedule.

Description: The goal of this program is to conduct outreach and training for stakeholders; including families, professionals, providers, self-advocates, and other advocates, for Marylanders with disabilities who need access to Medicaid health care services. ■

Home Health Third Party Liability Demonstration Arbitration

Project No: HHSM-500-2005-00033I
Project Officer: Diane Ross
Period: September 2005 to September 2011
Funding: $1,262,000.00
Principal Investigator: Pierre Paret
Award: Contract
Awardee: American Arbitration Association
601 Pennsylvania Avenue, NW
Washington, DC 20004-2676

Status: This contract has expired and was replaced with contract #HHSM-500-2010-00068C.

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 the Home Health Third Party Liability demonstration. ■

Hospice Outreach and Education Project

Project No: 1C0CMS030445/01
Project Officer: Cindy Massuda
Period: August 2009 to January 2011
Funding: $571,000.00
Principal Investigator: Amy Tucci
Award: Grant
Awardee: Hospice Foundation of America, Inc.
1621 Connecticut Ave, NW, Suite 300
Washington, DC 20009

Status: The following tasks have been completed for the grant: web-based services that feature video of individuals discussing experiences with hospice, and including advice from healthcare professionals on matters related to end-of-life care; a webcast related to cancer and end-of-life care; outreach brochures written in Spanish and Chinese to increase awareness of hospice to these populations, available for downloading from the website; webinars to underserved and rural populations on end-of-life issues such as cancer and end-of-life care, basics of the hospice Medicare benefit, recruiting and training hospice volunteers, Alzheimer's disease and end-of-life care, helping Veterans at the end of life, and aging and end-of-life issues in the LGBT community; webcasts related to end-of-life issues; and additional web-based services that feature video of individuals discussing experiences with hospice and including advice from healthcare professionals on matters related to end-of-life care.

Description: The goal of the project is to communicate the concept of hospice care to healthcare consumers who meet conditions to be served by hospice yet are unaware of it because of cultural, linguistic, or geographic barriers or lack of appropriate health and/or social service provider communications. The project leverages the experience of Hospice Foundation of America's educational focus through successful use of the internet, webinars, downloadable brochures, and access to experts via email and a toll-free phone number to reach its target audiences. ■

Hospital Acquired Condition Present on Admission (HAC-POA) Program Evaluation

Project No: HHSM-500-2005-00029I/HHSM-500-T0007
Project Officer: Linda Radey
Period: September 2009 to September 2011
Funding: $3,105,734.00
Principal Investigator: Nancy McCall
Kathleen Dalton
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Option year one has been approved. The period of performance is extended to September 29, 2011. The TO was modified to add a mandated Report to Congress on extending the Hospital Acquired payment policy to other types of facilities. The funding has increased from $714,874 by $2,390,860 to $3,105,734.

Description: This project evaluates the impact of the Hospital Acquired Condition Present on Admission (HAC-POA) program on the changes in the incidence of selected conditions, effects on Medicare payments, impacts on coding accuracy, unintended consequences, and infection and event rates. The evaluation will also examine the implementation of the HAC-POA program and evaluate additional conditions for future selection. The contractor will be required to design and conduct this program evaluation. The program evaluation will consist of an impact analysis of secondary data using quantitative and qualitative methods to examine the wide-ranging effects of the HAC-POA program and to suggest future enhancements to the program. This is an intra-agency project with funding and technical support coming from CMS, the Office of Public Health and Science (OPHS), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention (CDC). ■

Idaho Children's Access Card Demonstration

Project No: 21-W-00018/10 and 11-W-00187/10
Project Officer: Jeffrey Silverman
Period: November 2004 to September 2013
Funding: $ 0.00
Principal Investigator: Robin Pewtress
Award: Waiver-Only Project
Awardee: Division of Medical Services, Department of Health and Human Services
700 Main Street
Little Rock, AR 72203

Status: The parents' coverage component of the demonstration was extended through September 2011 under provisions of section 2111(b)(1)(B) of the Act (as enacted by section 112 of the Children's Health Insurance Reauthorization Act of 2009). Coverage for nonpregnant childless adults was transitioned to a new Medicaid demonstration (Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration), 11-W-00245/10) on January 1, 2010. On September 30, 2010, the children's component of the demonstration was extended for three years, to September 30, 2013.

Description: This demonstration provides children eligible for CHIP between 100% and 185% FPL the option of enrolling in the Access Card premium assistance program. Enrollment in the demonstration is in lieu of receiving benefits through direct coverage. It also provides a subsidy to uninsured parents of children who are eligible for Medicaid or CHIP with incomes up to 185% FPL. ■

Idaho Medicaid Non-Pregnant Childless Adult Waiver (Idaho Adult Access Card Demonstration)

Project No: 11-W-00245/10
Project Officer: Kelly Heilman
Period: December 2009 to September 2014
Funding: $ 0.00
Principal Investigator: Leslie Clement
Award: Waiver-Only Project
Awardee: Department of Health and Welfare, Division of Medicaid
3232 Elder Street
Boise, ID 83705

Status: Eighty-six childless adults received subsidies for the purchase of employer-sponsored insurance through this demonstration in September 2010.

Description: This demonstration provides a subsidy for employer sponsored insurance (ESI) coverage to uninsured childless adults who are not eligible for Medicaid with incomes up to 185% FPL. Prior to January 1, 2010, the population served by this demonstration received an identical benefit under title XXI through the Children's Access Card Demonstration (21-W-00018/10 and 11-W-00187/10). Section 2111(a) of the Social Security Act, as enacted by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009, ended title XXI funding for childless adults' coverage, and provided the opportunity for the State to request this Medicaid demonstration to continue coverage for the affected childless adult population through XXI. ■

Illinois Family Planning

Project No: 11-W-00165/05
Project Officer: Juliana Sharp
Period: June 2003 to March 2012
Funding: $ 0.00
Principal Investigator: Julie Hamos
Award: Waiver-Only Project
Awardee: Illinois Department of Healthcare and Family Services, Division of Medical Programs
201 S, Grand Avenue East 3rd Floor
Springfield, IL 62763-0001

Status: As of June 30, 2010, 107,335 individuals received family planning services under the Demonstration.

Description: This demonstration extends family planning services to women between the ages of 19 and 44 after losing eligibility under other Medicaid categories or the state program under title XXI, and for such women who lose eligibility under the approved HIFA demonstration and have family incomes at or below 200% FPL. ■

Impact of Increased Financial Assistance to Medicare Advantage Plans

Project No: 500-00-0024/0017
Project Officer: Melissa Montgomery
Period: August 2004 to June 2010
Funding: $1,249,917.00
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 has been completed and can be found at the following website: http://www.cms.hhs.gov/reports/downloads/Pope.pdf. The 2006 Final Report on Medicare Advantage Plan Availability, Premiums and Benefits, and Beneficiary Enrollment has been completed and can be found at the following website: http://www.cms.hhs.gov/Reports/Downloads/Pope_FAMA_2007.pdf. The 2007 and 2008 MA Monitoring Reports are in progress. Data issues which required additional work occurred on both reports. CMS finalized these reports in late Spring 2010.

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 and 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. In 2006, extensive program-wide changes (e.g., regional plans, competitive programs, and the Part D drug benefit) were implemented. CMS exercised the contract option to continue to monitor the MA program. The option phase of the contract focused on the post-MMA years (2006 through 2008), in which, the contractor examined plan availability, participation, plan premiums, benefits cost sharing, and enrollment. ■

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

Project No: 500-00-0033/0009
Project Officer: Iris Wei
Period: June 2005 to December 2009
Funding: $1,363,292.00
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 final report is undergoing Mathematica Policy Research's internal 508 compliance process. It will be available to the public after its submission and acceptance in the CMS 508 compliance review.

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 from 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. ■

Impacts Associated with the Medicare Psychiatric Prospective Payment System

Project No: 500-00-0024/0018
Project Officer: Fred Thomas
Period: September 2004 to March 2010
Funding: $839,772.00
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: A report on psychiatric co-morbidities has been released and is on the CMS Web site. A final report on the impact of the psychiatric PPS is complete and available at http://www.cms.gov/reports/downloads/Drozd_Psych2_Final_2010.pdf

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, and
- the use of two prospective payment systems to pay for essentially the same inpatient services. ■

Implementation & Evaluation of the Physician Group Practice Demonstration

Project No: HHSM-500-2005-00029I/0007
Project Officer: Heather Grimsley
Fred Thomas
Period: September 2007 to September 2011
Funding: $4,379,160.00
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: The contract was modified to add a 12 month extension through September 24, 2011 and the total estimated cost plus fixed fee was increased by $1,299,216 from $3,079,944 to $4,379,160.

Description: Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Physician Group Practice 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. 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 four performance years, all 10 of the participating physician groups continued to improve the quality of care for chronically ill patients by achieving benchmark or target performance on at least 29 out of the 32 quality markers for patients with diabetes, coronary artery disease, congestive heart failure, hypertension, and cancer screening. Over the first four years of the demonstration, physician groups increased their quality scores an average of 10 percentage points on the diabetes, 13 percentage points on the heart failure measures, six percentage points on the coronary artery disease measures, nine percentage points on the cancer screening measures, and three percentage points on the hypertension measures. As a result, all physician groups received at least 92 percent of their Physician Quality Reporting Initiative (PQRI) incentive payments which they agreed to place at risk for quality performance under the demonstration. The 10 physician groups earned PQRI incentive payments totaling $8.1 million. In addition, five physician groups earned $31.7 million in performance payments for improving the quality and cost efficiency of care as their share of a total of $38.7 million in Medicare savings. Additional physician groups had lower growth in expenditures than their local market area, but not sufficiently lower to share in savings under the demonstration's performance payment methodology. In total, the 10 physician groups earned performance payments for improving the quality and efficiency of care totaling $39.8 million in the fourth performance year. ■

Implementation and Monitoring, Support of the Medicare Hospital Gainsharing Demonstration

Project No: HHSM-500-2006-00005I/0003
Project Officer: Lisa Waters
Period: August 2006 to December 2013
Funding: $2,292,012.00
Principal Investigator: Franklin Eppig
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The contract was modified to give an order of preference to each task. The project is 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 and will also 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 will 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 resulting 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. Furthermore, the contractor will monitor admission and referral patterns at participating hospitals and neighboring hospitals to ensure that no significant or detrimental changes occur as a result of the demonstration. The implementation/ monitoring contractor shall work closely with the evaluation contractor to compliment each other's work and avoid unnecessary duplication of tasks. ■

Implementation of the Medicare Care Management Performance (MCMP) Demonstration

Project No: 500-2005-00029I/0014
Project Officer: Jody Blatt
Period: August 2008 to September 2011
Funding: $149,993.00
Principal Investigator: Musetta Leung
Award: Task Order (XRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This contract was awarded in August 2008 to provide ongoing support for the MCMP demonstration. The work for the MCMP demonstration under the

original contract ended at the end of FY 2009. In the summer of 2009, practices were paid an incentive for performance on 26 quality measures for the first demonstration year (July 2007- June 2008). This represents the second incentive payment under the demonstration. Last year, practices received an incentive for reporting baseline data. In addition, in the summer of 2008 and again in the fall of 2009, practices participating in this demonstration were able to earn PQRI incentive payments through their participation in the demonstration without having to submit duplicative data. Data collection for the second demonstration year (July 2008 - June 2009) began in early 2010.

Description: This contract is a follow on to the original data collection support contract for the MCMP demonstration. It will support ongoing data collection activities through the end of the demonstration. The original contract was 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, and 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 clinical 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 Certification Commission for Health Information Technology (CCHIT) certified electronic health record. The demonstration began July 1, 2007 with almost 700 practices and will run through June 30, 2010. Because of the retrospective nature of the clinical quality data collection process, activities under this contract will continue through FY 2011. ■

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

Project No: HHSM-500-2005-00029I/0001
Project Officer: Dennis Nugent
Period: September 2005 to September 2011
Funding: $1,851,987.00
Principal Investigator: Gregory Pope
Award: Task Order
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Development of the demonstration design is complete. Work is now being transitioned to the development and implementation of procedures for financial reconciliation. It is estimated that the amount of funding currently allotted will cover payment for the contractor's performance of work through September 2011.

Description: The contractor will assist with the design and implementation of individual demonstration projects under section 646 of the Medicare Modernization Act, including the development of specifications for intervention groups and the identification of valid comparison groups. After implementation the contractor will perform financial reconciliation for purposes of determining shared savings awards. ■

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

Project No: 500-00-0033/0012
Project Officer: Juliana Tiongson
Period: September 2005 to September 2011
Funding: $1,118,552.00
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 contractor continues to provide technical assistance in developing, refining, and implementing demonstrations. The contractor has performed waiver cost estimates for the The Frontier Extended Stay Clinic (FESC) demonstration and the Medicare Hospital Gainsharing Demonstration. The contractor continues to provide technical assistance for the Medicare Coordinated Care Demonstration.

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

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

Project No: 500-00-0028/0003
Project Officer: Siddhartha Mazumdar
Period: September 2004 to September 2011
Funding: $2,180,974.00
Principal Investigator: Sylvia Ramirez
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 two participating demonstration organizations. The contractor has also performed calculations of whether the organizations have met the targets established for each of the clinical measures. Since the organizations began enrolling ESRD patients early in 2006, Arbor Research has conducted the first eight semi-annual reconciliations, determining the quality incentive payment for the organizations.

Description: The purpose of this project is to provide implementation support for the quality incentive payment of the ESRD Disease Management Demonstration and to implement and provide 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/0004
Project Officer: Lisa Waters
Period: August 2007 to December 2013
Funding: $1,027,710.00
Principal Investigator: Franklin Eppig
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The demonstration has been operational since July 2009. The period of performance has been extended through 2013.

Description: This demonstration project will provide a test of gainsharing in the Medicare program. It will determine if gainsharing can align 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 and will collaborate with the evaluator to collect and store data required to effectively monitor and evaluate the demonstration. ■

Implementing the HEDIS (Healthcare Effectiveness Data and Information Set) Medicare Health Outcomes Survey

Project No: HHSM-500-2009-00051C
Project Officer: Sonya Bowen
William Long
Chris Haffer
Period: September 2009 to September 2011
Funding: $2,232,403.00
Principal Investigator: Kristen Spector
Award: Contract
Awardee: National Committee for Quality Assurance
1100 13th Street, NW
Washington, DC 20005

Status: This contract will allow NCQA to continue to manage the data collection and transmittal of the HEDIS Medicare Health Outcomes Survey and HOS-M to CMS

and to support the scientific development of the Medicare HOS and HOS-M measures from September 29, 2009 to September 28, 2014. This contract was awarded for one base year with four option years and is currently in its first option.

Description: The Medicare Health Outcomes Survey (HOS) is the first patient-based health outcome measure for the Medicare population. The survey assesses a Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over time, using the best available science in functional status and health outcomes measurement. Implemented in 1998, the survey is fielded nationally as a Healthcare Effectiveness Data and Information Set (HEDIS) measure. It is a longitudinal, self-administered survey, which utilizes the VR-12 health survey, as well as additional health status and case mix adjustment variables. Questions are also included to collect results for four HEDIS Effectiveness of Care measures. Each year, survey data are collected for a new sample (cohort) of Medicare managed care beneficiaries from each eligible MAO. Members who respond to the baseline survey are resurveyed two years later as a follow up. The survey is administered through a group of certified HOS vendors. 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 and reward high performance, [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. The HOS-M is a modified version of the Medicare HOS that is administered to vulnerable Medicare beneficiaries at greatest risk for poor health outcomes. Similar to the HOS, the HOS-M design is based on a randomly selected sample of individuals from each eligible Program of All-Inclusive Care for the Elderly (PACE) Organization. The HOS–M is cross–sectional, measuring the physical and mental health functioning of beneficiaries at a single point in time. The main purpose of the HOS-M is to assess annually the frailty of the population in these health plans in order to adjust plan payments. ■

Improving Access to Care for the Uninsured of Santa Cruz County, CA: Healthy Kids & Project Connect

Project No: 1C0CMS030438/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $238,000.00
Principal Investigator: Eleanor Littman
Award: Grant
Awardee: Health Improvement Partnership of Santa Cruz County
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Status: This project was scheduled to end on January 30, 2011. No other request for an extension has been received. OAGM will schedule for close out after final reports are received.

Description: The goal of this program is to continue Healthy Kids coverage for 1,810 Santa Cruz County children ages 6 to 18, living in families making less than 300% FPL, and not eligible for other coverage through June 30, 2010. Also, the program hopes to demonstrate quality improvement and cost effectiveness with the addition of a Patient Navigator to the Project Connect team to link uninsured adults discharged from acute care hospitals in Santa Cruz County to safety net clinics and reduce avoidable re-hospitalizations. ■

Improving Access to Health Care for Low-Income Residents of Bucks County

Project No: 1C0CMS030437/01
Project Officer: Carol Magee
Period: August 2009 to January 2011
Funding: $343,000.00
Principal Investigator: Sally Fabian
Award: Grant
Awardee: Bucks County Health Improvement Partnership
1201 Langhorne-Newton Road
Langhorne, PA 19047

Status: This Project's CMS funding ends in January 2011. The final report to CMS which covers the 1.5 years of this latest grant to the BCHIP Project (August 2009 to

January 2011) will be provided by the grant's stipulated deadline of April 30th, 2011.

Description: This program will provide an umbrella administrative framework to fund services and administratively link three free adult medical clinics throughout Bucks County, PA. These services and clinics, which were implemented earlier and funded per the BCHIP (Bucks County Health Improvement Partnership) Grant (grant number 18-P-91506/03 which ended September 2009), shall provide health services to the uninsured, as well as support a countywide dental program for dentally uninsured children ■

Improving End of Life Care Through Technology

Project No: 1C0CMS030280/01
Project Officer: Pamela Pope
Period: July 2008 to December 2010
Funding: $383,181.00
Principal Investigator: Karen Nichols
Award: Grant
Awardee: Valley Hospice, Inc.
10686 State Route 150
Rayland, OH 43943

Status: This project was scheduled to end on December 31, 2010. No other request for extension has been received, so OAGM will schedule for close out after final reports are received.

Description: The goal of this project is to develop affordable hospice specific software. ■

Improving HIV/AIDS Care and Treatment for Vulnerable Populations

Project No: 1C0CMS030265/01
Project Officer: Pamela Pope
Period: July 2008 to December 2009
Funding: $1,244,866.00
Principal Investigator: Sajid Shaikh
Award: Grant
Awardee: San Francisco Department of Public Health
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102

Status: This project closed in March of 2010 after receipt of final progress and financial reports.

Description: The HIV Health Services section of the San Francisco Department of Public Health requests FY 2008 earmark funding through the US Centers for Medicare & Medicaid Services to support a series of critical enhancements to the HIV/AIDS service delivery system in San Francisco, California. The goal of this program is to enhance the quality and length of life of underserved, minority, and low income populations living with HIV/AIDS, while creating cost-effective models of care and treatment access which will maximize utilization of Medicaid and Medicare funding streams. The objective of this project is to provide comprehensive HIV outreach, testing, and referral services for at least 995 high-risk, low-income men and women who are currently not receiving medical care. The program will also implement and test a range of innovative strategies for reaching and serving individuals living with HIV on low incomes, incorporating multi-disciplinary support services to help retain persons with low income in care and to ensure their long term utilization of HIV treatment and medications. ■

Improving Nursing Home Compare

Project No: HHSM-500-2005-00018I/0005
Project Officer: Leslie Boyd
Period: June 2008 to December 2009
Funding: $798,974.00
Principal Investigator: Alan White
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project came to a close in December 2009.

Description: The Centers for Medicare and Medicaid Services (CMS) engages in a number of activities to improve the quality of care in nursing homes. Among these are activities such as consumer awareness and value-based purchasing. To promote consumer awareness, CMS seeks to provide an array of understandable information that can be readily accessed by the public. Thus CMS maintains a web site that features "Nursing Home Compare," a resource that gives consumers comparative information on nursing home performance. Among other things, this resource includes certain quality measures (QMs) that are derived

from information collected via the minimum data set (MDS). Under the existing contract, CMS is planning to implement the Nursing Home Value-Based Purchasing (NHVBP) demonstration to improve the quality of care furnished to Medicare beneficiaries residing in nursing homes. CMS will assess the performance of participating nursing homes on selected quality measures, and then will make payments to nursing homes that have the best performance or the greatest improvement in quality of care. The domains of quality selected for the demonstration are: nurse staffing, avoidable hospitalizations, quality measures based on MDS, and information from state survey and certifications. CMS plans to improve Nursing Home Compare through the inclusion of a national nursing home rating system. We currently envision using a "five-star" rating system. The goal of the rating system is to provide useful information to consumers about how each nursing home performs in terms of quality. The rating system must be easy to understand while making meaningful distinctions in quality among nursing homes. ■

Improving Outcomes Using Medicare Health Outcomes Survey (HOS) Data

Project No: GS-10F-0166/HHSM-500-2006-00001G
Project Officer: William Long
Period: November 2005 to March 2011
Funding: $5,536,972.00
Principal Investigator: Laura Giordano
Award: GSA Order
Awardee: Health Services Advisory Group
3133 East Camelback Road, Suite 300
Phoenix, AZ 85016-4501

Status: Round thirteen data submission, cleaning, and analysis from the 2010 HOS field administration will be completed in early 2011. Cohort eleven performance measurements and cohort thirteen baseline results will be finalized and made available later in 2011. Calendar Year 2011 activities will also include collaborative work with the National Cancer institute (NCI) and the re-competition of the next contract.

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 Patient Outcomes for Chronically Ill and Elderly through Medication Management

Project No: 1C0CMS330732-01-00
Project Officer: Steve Blackwell
Period: June 2010 to May 2011
Funding: $100,000.00
Principal Investigator: Nancy Zionts
Award: Grant
Awardee: Jewish Healthcare Foundation
Centre City Tower, 2400650 Smithfield Street
Pittsburgh, PA 15222

Status: The project is active. The researchers have developed a library of interactive content and quality improvement project materials for widespread dissemination. Per the researchers, an interest among area hospitals for this information has been shown.

Description: This project will expand upon the pharmacy fellowship by identifying and resolving issues surrounding polypharmacy and medication integration, developing an online education curriculum and engaging physicians, pharmacist and other healthcare professionals in medication integration through team-based approaches. ■

Inpatient Rehabilitation Facility Classification System Analytic and Programming Support

Project No: HHSM-500-2006-00039C
Project Officer: Susanne Seagrave
Period: September 2006 to September 2010
Funding: $419,840.00
Principal Investigator: David Malitz
Award: Contract

Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

Status: The contract ended on September 30, 2010. All tasks have been completed.

Description: This contract will provide analytical and programming support to CMS in replicating and updating RAND's analyses associated with the Inpatient Rehabilitation Facility (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 Skilled Nursing Facility (SNF) resident population changes, and to update the IRF and SNF grouper methodology programming. ■

Insure the Uninsured

Project No: 1C0CMS030436/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $171,000.00
Principal Investigator: Sara Mishefkse
Award: Grant
Awardee: City of Milwaukee Health Department
841 North Broadway, 3rd Floor
Milwaukee, WI 53202

Status: This project was scheduled to end on January 30, 2011. No other requests for an extension have been received. OAGM will schedule for close out after final reports are received.

Description: The goal of this program is to build upon Medical Assistance (MA) and Outreach successes and expand the program significantly to improve access to and utilization of primary and preventive health care for low income individuals eligible for expanded Badger Care Plus program services. This goal will be achieved by intensifying efforts to reach childless adults by partnering with community based organizations and consumers. ■

Inter/Intra Agency Agreements for Federal Agency Research Requests

Project No: HHSM-500-2010-000011/HHSM-500-T0006
Project Officer: Kimberly Elmo
Period: August 2010 to August 2011
Funding: $159,118.00
Principal Investigator: Debbie Dean
Award: Task Order
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: The project is underway and on target.

Description: The purpose of this task is to provide data to customers paying through an Interagency Agreement, (IAA). Many federal agencies use IAAs as the mechanism for paying data fees. These requests will be processed by the CCS/RDDC contractor. Any data processing IAA's which do not involve a fee (for example, exchange of goods and services) will not be covered under this task. All payments for data processing shall be provided to CMS to support the CCW/RDDC contract. The contractor shall not receive or accept payments for the processing of data. ■

Iowa Family Planning

Project No: 11-W-00188/07
Project Officer: Juliana Sharp
Period: January 2006 to July 2011
Funding: $ 0.00
Principal Investigator: Jennifer Vermeer
Award: Waiver-Only Project
Awardee: Iowa Medicaid Enterprise, Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: As of September 30, 2010, 31,180 individuals received family planning services through the Demonstration. The Demonstration is set to expire on January 31, 2011, but was granted a temporary extension through July 1, 2011 to allow more time discuss the Demonstration's future.

Description: The Iowa Family Planning Demonstration Project extends Medicaid eligibility for family planning services to Medicaid-participating child-bearing aged women from the age of 13 through 44, as well as women losing Medicaid pregnancy coverage with incomes at or below 200% FPL. ■

IowaCare

Project No: 11-W-00189/07
Project Officer: Juliana Sharp
Period: July 2005 to December 2013
Funding: $ 0.00
Principal Investigator: Jennifer Vermeer
Award: Waiver-Only Project
Awardee: Iowa Medicaid Enterprise, Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: The Demonstration was renewed for three years on September 1, 2010. Under the Demonstration renewal, the State received authority to incrementally expand the primary care provider network. On October 1, 2010, the State expanded the primary provider care network to two Federally-Qualified Health Centers in Sioux City and Waterloo. As part of the renewal, the State will also implement a medical home pilot. As of October 1, 2010, there were 41,647 individuals enrolled in IowaCare. The Demonstration is currently scheduled to expire on December 31, 2013.

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% 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 2011
Funding: $ 0.00
Principal Investigator: Neville Wise
Award: Waiver-Only Project
Awardee: Kentucky, Department of Medicaid Services
275 East Main Street, 6 West A
Frankfort, KY 40621

Status: As of June 30, 2010, 149,500 individuals were enrolled in the demonstration. On October 29, 2010, the State requested to renew the demonstration, which is scheduled to expire October 31, 2011. The State's request is under review.

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. ■

Lean Healthcare Center of Excellence for Northeast Ohio

Project No: 1C0CMS030449/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $143,000.00
Principal Investigator: Mary Pacelli
Award: Grant
Awardee: MAGNET
1768 E. 25th Street
Cleveland, OH 44114

Status: The contractor requested a no cost extension on November 3, 2010. OAGM is processing this request.

Description: The project is designed to create a regional support system for healthcare institutions in the Mahoning Valley area to implement and sustain Lean and Six Sigma Improvement techniques. The program will benefit the patients, healthcare employees, providers, and healthcare institutions that receive services from CMS, and the region as a whole. The projects two main phases of activities are pilot work with Humility of Mary Health (HMH) Partners and the development of a Center of Excellence concept for the region. ■

Legal Representation - Arbitration Hearings (Home Health TPL)

Project No: HHSM-500-2006-00047C
Project Officer: Diane Ross
Period: September 2006 to September 2011
Funding: $2,174,487.00
Principal Investigator: Sharon Keyes
Award: Contract
Awardee: Blue Cross/Blue Shield Association
225 N. Michigan Avenue
Chicago, IL 60601

Status: The contractor continues to support CMS with the Home Health Third Party Liability Demonstration. The total estimated cost plus fixed fee for full performance of this contract, as modified, was increased by $402,209 from $1,772,278 to $2,174,487. The period of performance was also extended to September of 2011.

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. ■

Legal Representation in Arbitration Hearings for the Home Health Third party Liability (HHTPL) Demonstration

Project No: HHSM-500-2010-00056C
Project Officer: Diane Ross
Period: September 2010 to September 2011
Funding: $1,291,780.00
Principal Investigator: Sharon Keyes
Award: Contract
Awardee: Blue Cross/Blue Shield Association
225 N. Michigan Avenue
Chicago, IL 60601

Status: The project is underway.

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. ■

Long Term Trends in Medicare Payments in the Last Year of Life

Project No: CMS-ORDI-2010-2
Project Officer: Gerald Riley
Period: August 2008 to August 2010
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: An article based on findings from this study has been published. The citation is as follows: Riley GF, Lubitz JD. Long term trends in Medicare payments in the last year of life. HSR: Health Services Research. Vol. 45, no. 2, pp. 565-576. April 2010. Abstract: Objective: To update research on Medicare payments in the last year of life Data Source: Continuous Medicare History Sample, containing annual summaries of claims data on a five percent sample from 1978 to 2006. Study Design: Analyses were based on elderly beneficiaries in fee-for-service. For each year, Medicare payments were assigned either to decedents (persons in their last year) or to survivors (all others). Results: The share of

Medicare payments going to persons in their last year of life declined slightly from 28.3 percent in 1978 to 25.1 percent in 2006. After adjustment for age, sex, and death rates, there was no significant trend. Conclusions: Despite changes in the delivery of medical care over the last generation, the share of Medicare expenditures going to beneficiaries in their last year has not changed substantially.

Description: The objective of the study was to update previous research on the cost of Medicare services in the last year of life and identify long term trends. The study was based on the Continuous Medicare History Sample, which contains annual claims and enrollment data for a 30 year period for a five percent sample of Medicare beneficiaries. Analyses are based on aged beneficiaries entitled at any time during the period 1978-2006. Only years spent in Fee-for-Service (FFS) were included in the study. For any given year *t*, Medicare payments were assigned to decedent or survivor categories. For individuals dying in year *t+1*, payments in year *t* were prorated according to the proportion of year *t* that occurred in the last 12 months of life. ■

Louisiana Family Planning

Project No: 11-W-00232/06
Project Officer: Rebecca Burch Mack
Period: June 2006 to August 2011
Funding: $ 0.00
Principal Investigator: Don Gregory
Award: Waiver-Only Project
Awardee: Louisiana, Department of Health and Hospitals
628 North 4th Street, P. O. Box 91030
Baton Rouge, LA 70821-9030

Status: As of September 30, 2010, 78,270 individuals were enrolled in the Demonstration. The Demonstration is set to expire on August 31, 2011.

Description: This demonstration provides family planning services for uninsured women, aged 19 through 44, who are not otherwise eligible for Medicaid, State Children's Health Insurance Program, Medicare or any other creditable health care coverage, and who have family income at or below 200% FPL. ■

Louisiana Greater New Orleans Community Health Connection

Project No: 11-W-00252/06
Project Officer: Steven Rubio
Period: September 2010 to December 2013
Funding: $ 0.00
Principal Investigator: Don Gregory
Award: Waiver-Only Project
Awardee: Louisiana, Department of Health and Hospitals
628 North 4th Street, P. O. Box 91030
Baton Rouge, LA 70821-9030

Status: The demonstration was approved on September 22, 2010, and implemented on October 1, 2010.

Description: The Greater New Orleans Community Health Connection Demonstration allows the State to provide health care coverage to individuals who are non-pregnant adults ages 19 through 64 years, who are residents of the Greater New Orleans region, and whose family incomes that do not exceed 200% of FPL. Coverage is provided for a limited set of outpatient services provided by participating health clinics, or in the case of physician specialists services, for which referral was made by a participating clinic. All participating clinics are former recipients of grant funding under the Primary Care Access Stabilization Grant (PCASG) program, which expired on September 30, 2010. Budget neutrality is assured by requiring that Demonstration expenditures, when added to the total amount of supplemental payments made to disproportionate share hospitals (DSH), do not exceed the State's annual DSH allotment. By July 1, 2011, the State must submit a draft plan to CMS to evolve primary and behavioral health care access at participating clinics and to facilitate financial sustainability. The State's plan must also address how demonstration participants will be transitioned to new health care coverage options that will be available under national health reform in 2014. ■

Low Vision Rehabilitation Demonstration

Project No: ORDI-05-0002
Project Officer: James Coan
Period: April 2006 to March 2011
Funding: $ 0.00
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 will run for five years. The demonstration is occurring in New Hampshire, the greater New York City metropolitan area including all five boroughs, North Carolina, the greater Atlanta metropolitan area, Georgia, Kansas, and Washington state. The project is scheduled to expire on March 31, 2011.

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, 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 doctor's 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: Robin Preston
Period: September 2002 to December 2013
Funding: $ 0.00
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Maine, Department of Human Services
11 State House Station
Augusta, ME 04333

Status: CMS approved the three year extension request on September 20, 2010. The demonstration is scheduled to expire on December 31, 2013.

Description: This Demonstration extends coverage to childless adults and non-custodial parents with incomes up to 100% 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 HIV/AIDS Program

Project No: 11-W-00128/01
Project Officer: Robin Preston
Period: February 2000 to December 2013
Funding: $ 0.00
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Office of MaineCare Services (OMS)
11 State House Station
Augusta, ME 04333-0011

Status: CMS approved the three year extension request in July 2010. The demonstration is scheduled to expire on December 31, 2013.

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. ■

Maryland HealthChoice

Project No: 11-W-00099/03
Project Officer: Robin Preston
Period: October 1996 to December 2013
Funding: $ 0.00
Principal Investigator: John Folkemer
Award: Waiver-Only Project
Awardee: Maryland, Department of Health and Mental Hygiene
201 W. Preston Street, Room 525
Baltimore, MD 21201

Status: The State submitted its renewal request to continue the waiver until December 31, 2013. The renewal includes two previous amendment requests and two new programmatic changes. The first is a program to provide discounted prescription drugs to uninsured Marylanders up to 300% FPL; the second would provide premium subsidy for enrollees in the Maryland Health Insurance Program (high risk pool); the third request is to extend the FPL level to 250% for the family planning program; and the fourth request will offer private duty nursing to participants in the REM program.

Description: The HealthChoice Demonstration, operational on July 1, 1997, requires most Medicaid eligibles to receive their Medicaid coverage through capitated managed care plans. Savings from the managed care delivery system are used to fund a variety of eligibility expansions, including women losing Medicaid after a pregnancy-related period of eligibility eligible for family planning service only; individuals age 19 and over with income below 116 % FPL and under $4,000 in assets enrolled in the Primary Access to Care program; and certain institutionalized medically needy individuals over the age of 18 with incomes in excess of 300% of the Social Security Income Federal Benefit Rate enrolled in the Increasing Community Services Program. The Demonstration also implements managed care for title XXI Medicaid expansion children. ■

MassHealth

Project No: 11-W-00030/01
Project Officer: Juliana Sharp
Period: April 1995 to June 2011
Funding: $ 0.00
Principal Investigator: Terrence Dougherty
Award: Waiver-Only Project
Awardee: Boston, Office of Medicaid
1 Ashburton Place, 11th Floor, Room 1109
Boston, MA 02108

Status: The demonstration is entering its fourteenth year, and covers more than one million low-income individuals across the Commonwealth. With the help of this demonstration, the State has the highest health insurance coverage rate in the country, holding at around 97% of the population. On March 1, 2010, the State submitted an amendment request. On September 30, 2010, the State received approval of an amendment to increase the MassHealth pharmacy co-payments from $2 to $3 for generic prescription drugs and provide relief payments to Massachusetts hospitals. Additional aspects of the March 1, 2010 amendment request such as restoring authorization for Designated State Health Programs (DSHP) to 2007-2009 levels is currently under review. On June 30, 2010, the State submitted a request to renew the Demonstration. The Demonstration is currently scheduled to expire on June 30, 2011.

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 1995 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% 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. ■

Maternity Care Coalition

Project No: 1C0CMS030439/01
Project Officer: Beth Benedict
Period: August 2009 to January 2011
Funding: $285,000.00
Principal Investigator: JoAnne Fischer
Award: Grant
Awardee: Maternity Care Coalition
2000 Hamilton Street, Suite 205
Philadelphia, PA 19130

Status: The project is completing its first quarter of work. The grant is supporting the MOMobile program in the delivery of and referral for care to pregnant women and their infants, up to age one. The MOMobile program serves impoverished areas in Philadelphia and selected surrounding areas.

Description: This project will sustain operation of the MOMobile program, with the aim of improving maternal and infant health for at-risk communities in the greater Philadelphia area. ■

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

Project No: 500-00-0032/0013
Project Officer: Suzanne Rotwein
Period: July 2005 to June 2010
Funding: $2,288,389.00
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The contractor continued investigating state of the art business models for achieving collaborative partnerships and determining, through actionable research, how CMS can structure similar initiatives. The period of performance was extended at no cost to through June 30th, 2010 at which point the contract expired.

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. ■

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

Project No: 500-00-0047/0006
Project Officer: Susan Radke
Period: September 2005 to September 2010
Funding: $2,154,345.00
Principal Investigator: Julia Sykes
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has completed a MAXEM design report; MAXEM Implementation Report; the MAXPC design report as well as the MAXPC Implementation Report. All work has been successfully completed.

Description: The purpose of this task order is to have Medicaid eligibility and service claims experts develop business "rules" to transform Medicaid (and CHIP) person-level data records from the Medicaid Statistical Information System (MSIS) into records in the Medicaid Analytic eXtract (MAX) system. This task order was modified to exercise certain aspects of Option III under Task 4(d) of the statement of work, which includes the creation of a Medicaid Analytic eXtract Enroll Master (MAXEM) File and a Medicaid Analytic eXtract Provider Characteristics (MAXPC) File. In implementing Option III, Task 4 (d) "identifies and implements business 'rules' and validation activities for any proposed enhancements to MAX." The development of the MAXEM File is an activity that is an enhancement to MAX and, therefore, is within the current scope of work for Task 4(d). Under this task the contractor will work toward unduplicating person records in the MAX files, first as a prototype and then produce this file, on a calendar year basis, to contain an Enrollee Master file record for each record found in the Person Summary File (PSF) from each state and the District of Columbia. The creation of a MAXPC file is another MAX enhancement activity under Option III Task 4(d). Currently, there are no provider characteristic data on Medicaid providers available to researchers. The work completed under this task will develop a prototype Provider Characteristic (PC) Master data set. This resulting data set will include information on commonly available characteristics for individual and organizational providers (e.g. Medicaid provider identifiers, Medicare and other linking provider identifiers, provider names, addresses, solo versus group practices and provider types/specialties) from State Medicaid agencies and provide a standard data set of provider characteristics across States. These files would

be linkable to MAX claims records by using State-assigned Medicaid provider identifiers. Interested parties about MAX may obtain additional information at the CMS MAX Web site: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp ■

Medicaid Analytic eXtract production, Enhancement, and Data Quality MAX-PDQ

Project No: HHSM-500-2005-00025I/HHSM-500-T0002
Project Officer: Susan Radke
Period: April 2010 to August 2013
Funding: $7,649,725.00
Principal Investigator: Don Lara
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The project is underway.

Description: The purpose of this task order is to produce person level data files on Medicaid eligibility, service utilization and payment information to support Comparative Effectiveness Research that is funded by the American Recovery and Reinvestment Act of 2009 (ARRA). As a component of the ARRA, CMS has been approved by the Department of Health and Human Services to produce and enhance the Medicaid Analytic eXtract file (MAX). This task order allows the continuation of transforming Medicaid Statistical Information System (MSIS) data into Medicaid Analytic eXtract (MAX) data which merges Medicaid demographic and claims information as well as converts fiscal year quarters into a calendar year. The purpose of MAX is to organize Medicaid data and make it usable for researchers to support research and policy analysis on Medicaid populations. In addition to producing MAX data, the contractor will also design, develop, and establish an early release version of MAX data identified in this task as "Beta MAX" so that researchers may obtain Medicaid data more timely for Comparative Effectiveness Research (CER). This task order also provides options to continue major activities that enhance MAX data. ■

Medicaid Infrastructure Grants - States A to M

Project No: 2009-MIG-AM
Project Officer: Effie George
Joseph Razes
Period: October 2000 to December 2009
Funding: $101,735,190.00
Award: Grant
Awardee: See Status
The awardees are included in the status.

Status: Here are the statuses of each of the 2009 Medicaid Infrastructure Grants sorted in alphabetical order from letter A to M:

State: Alabama (Y2)

Grant Number: 1QACMS030229/02

Awardee: Alabama Department of Rehabilitation Services

Annual Funding: $500,000

Project Investigator: Karen Coffey

State: Alaska (Y1)

Grant Number: 1QACMS030312/01

Awardee: Alaska Governor's Council on Disabilities & Special Education

Annual Funding: $750,000

Project Investigator: Millie Ryan

State: Arizona (Y3)

Grant Number: 1QACMS300122/03

Awardee: Arizona Health Care Cost Containment System

Annual Funding: $750,000

Project Investigator: Dara Johnson

State: Arkansas (Y2)

Grant Number: 1QACMSS030230/02

Awardee: Arkansas Department of Human Services

Annual Funding: $682,000

Project Investigator: Scott Holladay

State: California (Y1)

Grant Number: 1QACMS030313/01

Awardee: San Diego State University Research Foundation/Interwork Institute

Annual Funding: $2,640,006

Project Investigator: Eric Glunt

State: Connecticut (Y4)

Grant Number: 1QACMS300050/04

Awardee: Connecticut Department of Social Services/ Bureau of Rehabilitation Services

Annual Funding: $4,631,665

Project Investigator: Amy Porter

State: District of Columbia (Y3)

Grant Number: 1QACMS300125/03

Awardee: District of Columbia, Department of Health Care Finance

Annual Funding: $750,000

Project Investigator: Allen Jensen

State: Florida (Y2)

Grant Number: 1QACMS030231/02

Awardee: Florida Agency for Persons with Disabilities

Annual Funding: $750,000

Project Investigator: John Bartow Black

State: Hawaii (Y3)

Grant Number: 1QACMS300120/03

Awardee: University of Hawaii Center on Disability Studies

Annual Funding: $750,000

Project Investigator: Susan Miller

State: Idaho (Y1)

Grant Number: 1QACMS030327/01

Awardee: Idaho State Independent Living Council

Annual Funding: $500,000

Project Investigator: Rachel Johnstone

State: Illinois (Y3)

Grant Number: 1QACMS300121/03

Awardee: Illinois Department of Healthcare and Family Services

Annual Funding: $500,000

Project Investigator: Sandra Mott

State: Indiana (Y2)

Grant Number: 1QACMS030232/02

Awardee: Indiana Family & Social Services Administration

Annual Funding: $750,000

Project Investigator: Theresa Koleszar

State: Iowa (Y2)

Grant Number: 1QACMS030233/02

Awardee: Iowa Department of Human Services

Annual Funding: $744,000

Project Investigator: Jennifer Steenblock

State: Kansas (Y3)

Grant Number: 1QACMS300127/03

Awardee: Kansas Health Policy Authority

Annual Funding: $750,000

Project Investigator: Mary Ellen O'Brien Wright

State: Louisiana (Y4)

Grant Number: 1QACMS300052/04

Awardee: Louisiana State Department of Health & Hospitals

Annual Funding: $750,000

Project Investigator: Mack Marsh

State: Maine (Y1)

Grant Number: 1QACMS030316/01

Awardee: State of Maine Department of Health & Human Services

Annual Funding: $750,000

Project Investigator: Larry Glantz

State: Maryland (Y3)

Grant Number: 1QACMS300119/03

Awardee: Maryland Department of Disabilities

Annual Funding: $600,000

Project Investigator: Jade Gingerich

State: Massachusetts (Y2)

Grant Number: 1QACMS030234/02

Awardee: University of Massachusetts Medical School

Annual Funding: $5,600,409

Project Investigator: Shelley Stark

State: Michigan (Y3)

Grant Number: 1QACMS300124/03

Awardee: Michigan Department of Community Health

Annual Funding: $750,000

Project Investigator: Michael Head

State: Minnesota (Y1)

Grant Number: 1QACMS030325/01

Awardee: Minnesota Department of Human Services

Annual Funding: $5,434,648

Project Investigator: MaryAlice Mowry

State: Montana (Y1)

Grant Number: 1QACMS030322/01

Awardee: Montana Department of Public Health & Human Services

Annual Funding: $750,000

Project Investigator: Barbara Kriskovich

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. ■

Medicaid Infrastructure Grants - States N to W

Project No: 2009-MIG-NW
Project Officer: Effie George
Joseph Razes
Period: October 2000 to December 2009
Funding: $101,735,190.00
Award: Grant
Awardee: See Status
The awardees are included in the status.

Status: Here are the statuses of each of the 2009 Medicaid Infrastructure Grants sorted in alphabetical order from letter N to W:

State: Nebraska (Y4, NCE)

Grant Number: 11-P-92404/7-04

Awardee: Nebraska Department of Health & Human Services System

Annual Funding: n/a

Project Investigator: Sharon Johnson

State: Nevada (Y1)

Grant Number: 1QACMS030324/01

Awardee: Nevada Department of Health & Human Services

Annual Funding: $500,000

Project Investigator: Charles Duarte

State: New Hampshire (Y3)

Grant Number: 1QACMS300123/03

Awardee: New Hampshire Department of Health & Human Services

Annual Funding: $1,480,863

Project Investigator: Denise Sleeper

State: New Jersey (Y3)
Grant Number: 1QACMS300118/03
Awardee: New Jersey Department of Human Services
Annual Funding: $500,000
Project Investigator: William Ditto

State: New Mexico (Y1)
Grant Number: 1QACMS030328/01
Awardee: New Mexico Human Services Department
Annual Funding: $1,592,000
Project Investigator: Ernesto Rodriguez

State: New York (Y1)
Grant Number: 1QACMS030318/01
Awardee: New York State Office of Mental Health
Annual Funding: $5,992,413
Project Investigator: John Allen

State: North Carolina (Y1)
Grant Number: 1QACMS030326/01
Awardee: North Carolina Division of Vocational Rehabilitation Services
Annual Funding: $600,000
Project Investigator: Wayne Howell

State: North Dakota (Y4)
Grant Number: 1QACMS300054/04
Awardee: Minot State University
Annual Funding: $750,000
Project Investigator: Tom Alexander

State: Ohio (Y1)
Grant Number: 1QACMS030330/01
Awardee: Ohio Department of MRDD
Annual Funding: $500,000
Project Investigator: Leslie Paull

State: Oregon (Y1)
Grant Number: 1QACMS030315/01
Awardee: Oregon Department of Human Services
Annual Funding: $750,000
Project Investigator: Sara Kendall

State: Pennsylvania (Y1)
Grant Number: 1QACMS030323/01
Awardee: Pennsylvania Department of Public Welfare
Annual Funding: $5,327,141
Project Investigator: Constance Meeker

State: Rhode Island (Y1)
Grant Number: 1QACMS030321/01
Awardee: University of Rhode Island
Annual Funding: $750,000
Project Investigator: Elaina Goldstein

State: South Dakota (Y4)
Grant Number: 1QACMS300057/04
Awardee: South Dakota Department of Human Services
Annual Funding: $500,000
Project Investigator: Grady Kickul

State: Texas (Y2)
Grant Number: 1QACMS030236/02
Awardee: Texas Department of Assistive & Rehabilitative Services
Annual Funding: $750,000
Project Investigator: Lynn Blackmore

State: Utah (Y1)
Grant Number: 1QACMS030319/01
Awardee: Utah Department of Health
Annual Funding: $750,000
Project Investigator: Carol Ruddell

State: Vermont (Y1)

Grant Number: 1QACMS030320/01

Awardee: Department of Aging and Independent Living

Annual Funding: $750,000

Project Investigator: Susan Wells

State: Virginia (Y2)

Grant Number: 1QACMS030237/02

Awardee: Virginia Department of Medical Assistance Services

Annual Funding: $750,000

Project Investigator: Jack Quigley

State: Washington (Y1)

Grant Number: 1QACMS030317/01

Awardee: Washington State Department of Social & Health Services

Annual Funding: $750,000

Project Investigator: Stephen Kozak

State: West Virginia (Y4)

Grant Number: 1QACMS300059/04

Awardee: West Virginia Division of Rehabilitation Services

Annual Funding: $750,000

Project Investigator: Jack Stewart

State: Wisconsin (Y1)

Grant Number: 1QACMS030314/01

Awardee: Wisconsin Department of Health & Family Services

Annual Funding: $9,881,187

Project Investigator: Jacquelyn Wenkman

State: Wyoming (Y3)

Grant Number: 1QACMS300126/03

Awardee: University of Wyoming College of Health Sciences

Annual Funding: $750,000

Project Investigator: David 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. ■

Medicaid Statistical Information System (MSIS) Data Quality Support

Project No: HHSM-500-2005-00025I/0009
Project Officer: Katurah Spence
Period: September 2008 to September 2011
Funding: $4,606,345.00
Principal Investigator: Suzanne Dodds
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research (Cambridge)
50 Church Street
Cambridge, MA 02138-3726

Status: The contractor continues to perform technical support for the quality of state-submitted MSIS data by performing validation reviews of these data. They continue to work with states to improve the ongoing quality of their MSIS data submissions, addressing coding and data definition issues. In addition, the contractor works with states to improve the quality of their MMA data. The work on this project is ongoing. Option year II was exercised, extending the period of performance through September 29, 2011. The estimated cost of this Task Order is increased by $1,518,336 from $2,736,948 to $4,255,284. The fixed fee is increased by $125,263 from $225,798 to $351,061. The total estimated cost plus fixed fee is $4,606,345.

Description: The contractor will provide technical support to states as states submit one eligibility file and four claims files quarterly through the Medicaid Statistical Information System (MSIS). The contractor will use validation tools to analyze the quality of each MSIS data file and provide feedback tables to CMS

and the states. 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 states as they submit monthly dual-eligible data to CMS as required in the Medicare Modernization Act of 2003 (MMA). The contractor will use validation tools to analyze the monthly dual-eligible data and provide feedback tables to CMS and the states. ■

Medical Home Demonstration Implementation

Project No: HHSM-500-2005-00026I/0001
Project Officer: James Coan
Period: September 2008 to September 2013
Funding: $2,849,193.00
Principal Investigator: A Weiss
Award: Task Order (MRAD)
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: After the contract was awarded, necessary infrastructure to conduct recruitment, application and qualification processes for eligible physician-based practices were being developed. Recruitment was expected to begin in 2009. However, due to delays in the clearance process CMS has decided to postpone implementation and to wait until pending legislation that might repeal the Medicare Medical Home Demonstration described in section 204 of the Tax Relief and Health Care Act of 2006. According to pending language, a new medical home demonstration would replace it with a similar effort.

Description: CMS plans to conduct a Medical Home Demonstration as directed by Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA). The Act calls for the project to provide targeted, accessible, continuous, and coordinated family-centered care to high-need populations through a Medical Home demonstration. The Act also specifies that the demonstration will include Medicare beneficiaries who are deemed to be "high-need" (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.) The Medical Home Demonstration will be conducted in up to eight states including urban, rural and underserved areas, over a three year period. CMS planned to identify the demonstration locales in early 2009. The Implementation Contractor is expected to identify, recruit and register interested physician practices within demonstration locales (not yet determined) to participate in the Medical Home Demonstration, and to enroll beneficiary participants into Medical Homes by collecting beneficiary Agreement/Acceptance forms submitted by Medical Homes. The Implementation Contractor will be responsible for applying risk adjustment methodology to the list of beneficiary participants to determine the appropriate monthly Medical Home fee to be paid. Additionally, the Implementation Contractor will conduct the process to recognize qualified physician practices as Medical Home practices and determine their appropriate Medical Home tier at the beginning of the demonstration and also upon request of a practice seeking to qualify for a higher Medical Home tier. The Implementation Contractor will coordinate with the Medical Home Payment Contractor by transmitting files of recognized Medical Home practices and their tier, transmitting files of personal physicians and the Medical Home they are affiliated with, and transmitting risk adjusted files of beneficiary participants. Recruitment of physician practices is expected to begin in March 2009. Payment of monthly Medical Home fees will begin January, 2010. The Implementation Contractor will monitor participating practices to assure the Medical Home model is being appropriately implemented. ■

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

Project No: HHSM-500-2005-00029I/0010
Project Officer: Cynthia Mason
Period: September 2007 to September 2012
Funding: $1,199,765.00
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: All five selected sites have implemented the three year demonstration.

Description: This Task Order provides assistance to CMS in the development, site solicitation, implementation, and management of the Acute Care Episode (ACE) demonstration. The assistance includes 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 Chronic Care Practice Research Network

Project No: 1C0CMS030290/01
Project Officer: Juliana Tiongson
Period: July 2008 to December 2009
Funding: $646,505.00
Principal Investigator: Julie Fieldsend
Award: Grant
Awardee: Avera McKennan Hospital and University Health Center
2020 S. Norton Avenue
Sioux Falls, SD 57105

Status: The grant was awarded and the Medicare Chronic Care Research Practice Network has obtained a contractor to perform some analysis regarding care coordination interventions and strategies. The Network has also held conferences with national experts to brainstorm new interventions that could be useful in the chronically ill Medicare population. A final report was submitted identifying best practice sites and a clearly defined target population for future care coordination studies.

Description: The purpose of this project is to serve as the leading national resource available to advance the science and operational standards of care management for the chronically ill Medicare population with attention to widespread adoption and relevance to new and improved payment policies. ■

Medicare Chronic Care Practice Research Network (MCCPRN) - Phase II

Project No: 1C0CMS030290/01
Project Officer: Juliana Tiongson
Period: July 2008 to December 2010
Funding: $666,000.00
Principal Investigator: Julie Fieldsend
Award: Grant
Awardee: Avera McKennan Hospital and University Health Center
2020 S. Norton Avenue
Sioux Falls, SD 57105

Status: The grant period is over; however, CMS is still awaiting the final delivery of a design report and operational protocols.

Description: The goal of this program is to continue providing improvements in care coordination for frail older persons. The network is in the process of developing operational protocols detailing highly effective care coordination services. They are also developing a financial model to ensure savings to the Medicare program. ■

Medicare Contractor Provider Satisfaction Survey (MCPSS)

Project No: HHSM-500-2009-00057C
Project Officer: Teresa Mundell
Period: August 2009 to August 2014
Funding: $1,700,000.00
Principal Investigator: Jean Orelein
Award: Contract
Awardee: SciMetrika, LLC
100 Capitola Drive Suite 104
Durham, NC 27713

Status: The MCPSS is underway. This five year contract will expire August 26, 2014.

Description: The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to measure 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 use provider satisfaction as an additional measure to evaluate performance of key services performed by Medicare contractors and to encourage improvement efforts by contractors to ensure quality service. ■

Medicare Current Beneficiary Survey (MCBS)

Project No: HHSM-500-2009-00011C
Project Officer: William Long
Period: February 2009 to February 2014
Funding: $80,376,381.00
Principal Investigator: Richard Apodaca
Award: Contract
Awardee: Westat Corporation
1650 Research Blvd.
Rockville, MD 20850-3129

Status: The MCBS has been in the field continuously since Fall 1991. It is currently in its 58th round of

interviewing. To date, public use data files are available for 1991 through 2008.

Description: The MCBS is an ongoing, multi-purpose, face-to-face survey of a representative sample of the Medicare population. It is sponsored by CMS and operated by the agency's Office of Research, Development, and Information (ORDI). CMS's primary mission is the administration of Medicare (health insurance for the aged and disabled) and assisting the states in administering the Medicaid program (grants to states for medical assistance programs). Aside from collecting information on the financial aspects of the Medicare program, the MCBS also focuses on measuring the effectiveness of CMS' education outreach efforts. Through a series of supplements, the MCBS has monitored just how well CMS is doing with educating the Medicare population about the program and the underutilized benefits that are available, such as the "Welcome to Medicare" one-time physical and a multitude of preventative services. Essentially, these data provide the opportunity to qualify many of the CMS's Strategic Plan objectives and to measure beneficiary information needs. Specifically, the MCBS involves the beneficiaries in defining their health care information needs by aggregating and using data for continuous policy and process improvement and assesses outreach by the Medicare program and general knowledge of the Medicare program (services and health care choices) by the beneficiaries. ■

Medicare Grouper Evaluation and Physician Profiling Issues

Project No: HHSM-500-2006-00006I/0014
Project Officer: Fred Thomas
Period: August 2008 to October 2013
Funding: $1,499,459.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: An evaluation design report is being written and plans are being finalized to run the episode grouper software that will be developed under other CMS contracts.

Description: During a recent Government Accountability Office (GAO) study it was found 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 possibly used with financial incentives to change this behavior. In light of the continuing policy debate, and to test the application of these concepts in Medicare, CMS desired a contractor to continue the work performed under the Episodic Grouper Evaluation contract. Under this contract, Acumen will provide analytical support to help assess the various episode grouping projects that end on December 31, 2011. The project will then continue to support the development of an episode grouper. ■

Medicare Part D Program Evaluation

Project No: HHSM-500-2005-00029I/0009
Project Officer: Benjamin Howell
Period: September 2007 to June 2011
Funding: $183,714.00
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 report on the Impact of Part D on A/B Costs and Utilization was released in May 2010. A report examining the impact of Part D on A/B costs and medication adherence for beneficiaries with chronic conditions was finalized in December 2010 and is scheduled for release in early 2011. A contract modification was awarded in 2010 to supplement the analyses of A/B costs and medication adherence for beneficiaries with chronic conditions with an additional year's worth of data. The final report on these supplemental analyses is expected in April 2011.

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 Medicare 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. The other two components involve analyses of the impact of the Part D benefit on the Medicare Advantage program and on beneficiaries with chronic conditions. ■

Medicare Physician Fee Schedule - Review of Payment Localities Geographic Practice Cost Indices (GPCI)

Project No: HHSM-500-2006-00006I/0012
Project Officer: Craig Dobyski
Period: March 2008 to June 2010
Funding: $182,510.00
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: This project is complete.

Description: Using data collected for the GPCI update of 2008, the contractor shall examine several alternatives to the existing physician payment locality structure, provide information regarding the impacts of implementing each alternative payment locality structure, and provide GPCI values associated with each of the alternative payment locality structures. ■

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 2011
Funding: $ 1,000.00
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 and is in its sixth year. There are currently fifteen 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 Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
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 and is in its sixth year. There is currently 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, and the Children's Health Insurance Program (CHIP), 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 - JEN Associates, Inc.

Project No: HHSM-500-2005-00023I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: JEN Associates, Inc.
P.O. Box 39020
Cambridge, MA 02139

Status: This is an umbrella contract and is in its sixth year. 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, and the Children's Health Insurance Program (CHIP), 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 - Lewin

Project No: HHSM-500-2005-00024I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: This is an umbrella contract and is in its sixth year. Currently there are seven 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, and the Children's Health Insurance Program (CHIP), 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 - Rand Corporation

Project No: HHSM-500-2005-00028I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
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 and is in its sixth year. Currently there are seven 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, and the Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
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 and is in its sixth year. Currently, there are four 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, and the Children's Health Insurance Program (CHIP), 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 - Research Triangle Institute

Project No: HHSM-500-2005-00029I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
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, and is in its sixth year. Currently there are twenty-eight 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, and the Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: This is an umbrella contract and is currently in its sixth year. Currently there are five 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, and the Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
Award: Master Contract, Base

Awardee: University of Wisconsin - Madison
750 University Avenue
Madison, WI 53706

Status: This is an umbrella contract and is in its sixth year. 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, and the Children's Health Insurance Program (CHIP), 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 - Urban Institute

Project No: HHSM-500-2005-00030I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Status: This is an umbrella contract and is in it sixth year. 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, and the Children's Health Insurance Program (CHIP), 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 - Abt Associates

Project No: HHSM-500-2005-00018I
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
Award: Task Order Contract, Base
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: This is an umbrella contract and is in its sixth year. Currently there are seven 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, and the Children's Health Insurance Program (CHIP), 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-500-2005-000191
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: American Institute for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007-3835

Status: This is an umbrella contract and is in its sixth year. Currently there are three 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, and the Children's Health Insurance Program (CHIP), 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-500-2005-000201
Project Officer: Leslie Mangels
Period: September 2005 to September 2011
Funding: $ 1,000.00
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 and is in its sixth year. Currently there are three 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, and the Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: C.N.A. Corporation
4825 Mark Center Drive
Alexandria,VA 22311-1850

Status: This is an umbrella contract and is in its sixth year. 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, and the Children's Health Insurance Program (CHIP), 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 2011
Funding: $ 1,000.00
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 and is in its sixth year. Currently there are three 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, and the Children's Health Insurance Program (CHIP), in addition to other CMS program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Miami Jewish Home and Hospital Palliative Care Learning Series

Project No: 1C0CMS030450/01
Project Officer: Dennis Nugent
Period: August 2009 to January 2011
Funding: $214,000.00
Principal Investigator: Mimi Pink
Award: Grant
Awardee: Miami Jewish Health Systems
5200 NE 2nd Avenue
Miami, FL 33137

Status: Miami Jewish Health Systems has been conducting a series of lectures on palliative medicine at hospitals and other health care venues throughout south Florida. Each lecture focuses on one of the following topics: How Palliative Care Improves Patient Satisfaction in Primary Care Practices Top Health Care Provider Requirements for Palliative Care Services Palliative Care Hallmarks: Pain and Symptom Management End of Life: Aging, Hospice, and Palliative Care In addition to these onsite presentations the lectures have been videotaped for dissemination on MJHS' website in order to reach the widest audience. The project's final report will include a commentary on palliative care knowledge and recommendations from multiple MJHS personnel who have been involved with the project on payment policy for this type of care.

Description: The objective of this project is to educate the health care community on what constitutes palliative care and how it can improve patient and family satisfaction. The funding will be used to develop, deliver, document, and disseminate a series of four lectures to inform physicians and other health care providers on the history, philosophy, value, and future of palliative care. The target audience is health care providers serving the Miami-Dade area. ■

Michigan Family Planning

Project No: 11-W-00215/05
Project Officer: Juliana Sharp
Period: March 2006 to March 2011
Funding: $ 0.00
Principal Investigator: Steve Fritton
Award: Waiver-Only Project
Awardee: Michigan Department of Community Health, Medical Services Administration
Capitol Commons Center, 7th Floor, 400 S. Pine Street
Lansing, MI 48909

Status: As of September 30, 2010, 66,045 individuals were enrolled in the Demonstration. The Demonstration is set to expire on March 30, 2011.

Description: This demonstration covers family planning services for women ages 19 through 44, who are not otherwise eligible for Medicaid, the State's HIFA, or other coverage that provides family planning services and who have family income at or below 185% FPL. ■

Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)

Project No: 11-W-00245/05
Project Officer: Kelly Heilman
Period: December 2009 to September 2014
Funding: $ 0.00
Principal Investigator: Steve Fritton
Award: Waiver-Only Project
Awardee: Michigan Department of Community Health, Medical Services Administration
Capitol Commons Center, 7th Floor, 400 S. Pine Street
Lansing, MI 48909

Status: As of October 31, 2010, 66,232 individuals were enrolled in this Demonstration.

Description: The Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver) allows the State to receive title XIX funds to provide a limited ambulatory benefit package to low income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35% FPL who are not eligible for Medicaid. Prior to January 1, 2010, the population served by this demonstration received identical coverage under title XXI through the Adult Benefits Waiver Demonstration (21-W-00017/5). Section 2111(a) of the Social Security Act, as enacted by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009, ended title XXI funding for childless adults' coverage, and provided the opportunity for the State to request this Medicaid demonstration to continue coverage for the affected childless adult population through XIX. ■

Minnesota Family Planning

Project No: 11-W-00183/05
Project Officer: Juliana Sharp
Period: July 2004 to June 2011
Funding: $ 0.00
Principal Investigator: Brian Osberg
Award: Waiver-Only Project
Awardee: Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: On June 29, 2010, the State requested an extension of the Demonstration which is set to expire on June 30, 2011; the request is pending. As of June 30, 2010, there were over 18,000 individuals enrolled in the Demonstration.

Description: This demonstration covers family planning services for five years for men and women between the ages of 15 and 50 whose household incomes are at or below 200% FPL. ■

Minnesota Prepaid Medical Assistance Project Plus

Project No: 11-W-00039/05
Project Officer: Jessica Schubel
Period: April 1995 to June 2011
Funding: $ 0.00
Principal Investigator: Brian Osberg
Award: Waiver-Only Project
Awardee: Department of Human Services, MN
P. O. Box 64998
St. Paul, MN 55164-0998

Status: State submitted its renewal request on June 29, 2010. CMS is still reviewing the renewal requests and previously submitted amendment requests. The Demonstration will expire on June 30, 2011.

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% FPL and parents/caretaker relatives with income up to 275% 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. ■

Mississippi Family Planning

Project No: 11-W-00157/04
Project Officer: Juliana Sharp
Period: January 2003 to September 2011
Funding: $ 0.00
Principal Investigator: Robert L. Robinson
Award: Waiver-Only Project
Awardee: State of Mississippi, Division of Medicaid
Walter Sillers Building, Suite 1000, 550 High Street
Jackson, MS 39201-1399

Status: As of March 31, 2010, 24,578 individuals were enrolled in the Demonstration. The Demonstration is set to expire on September 30, 2011.

Description: This demonstration provides coverage for family planning services to women with income at or below 185% FPL. ■

Missouri Family Planning

Project No: 11-W-00236/07
Project Officer: Juliana Sharp
Period: October 2007 to January 2011
Funding: $ 0.00
Principal Investigator: Ian McCaslin
Award: Waiver-Only Project
Awardee: Missouri, Department of Social Services, Division of Medical Services
615 Howerton Court, P.O. Box 6500
Jefferson City, MO 65102

Status: On March 26, 2010, the State requested a three year extension of the Demonstration; the request is pending. The Demonstration was originally scheduled to expire on September 30, 2010, and is currently operating under a temporary extension through January 31, 2011. As of April 30, 2010, approximately 63,000 individuals were enrolled in the Demonstration.

Description: This demonstration provides family planning services to uninsured postpartum women ages 18 to 55 who lose Medicaid eligibility 60 days after the birth of their child for a maximum of one year after their Medicaid eligibility expires. ■

Missouri Gateway to Better Health

Project No: 11-W-00250/07
Project Officer: Juliana Sharp
Period: July 2010 to December 2013
Funding: $ 0.00
Principal Investigator: Ian McCaslin
Award: Waiver-Only Project
Awardee: Missouri, Department of Social Services, Division of Medical Services
615 Howerton Court, P.O. Box 6500
Jefferson City, MO 65102

Status: On July 28, 2010, CMS approved a new section 1115 demonstration, entitled Missouri Gateway to Better Health. The Demonstration provides support for the safety-net care providers in the St. Louis Region for two years. On July 1, 2012, the State will implement a coverage initiative to provide health insurance coverage for low-income individuals in the St. Louis Region. The Demonstration is currently scheduled to expire on December 31, 2013.

Description: Under the Demonstration, the State will spend up to $30 million (total computable) annually to preserve and improve primary and specialty care in the St. Louis region. To maintain budget neutrality, the State will ensure that these amounts, when added to payments to disproportionate share hospitals (DSHs) will not exceed the DSH allotment calculated in accordance with section 1923 of the Social Security Act. From July 28, 2010 (the date of the award letter) through June 30, 2012, as the State works to devise strategies to ensure the financial sustainability of the area's safety net system, the State will have authority to divert DSH funds to pay for otherwise uncompensated ambulatory care at specific facilities for the approved Demonstration period. These entities include St. Louis ConnectCare, Grace Hill Neighborhood Health Center, and Myrtle Hilliard Davis Health Center. By July 1, 2012, the State must implement a pilot program, subject to review and approval by CMS, to provide health insurance coverage to uninsured individuals residing in St. Louis City and St. Louis County with family income at or below 133% FPL. ■

Monitoring Chronic Disease Care and Outcomes Among Elderly Medicare Beneficiaries with Multiple Chronic Diseases

Project No: HHSM-500-2005-00027I/0001
Project Officer: Pauline Karikari-Martin
Period: September 2005 to January 2011
Funding: $881,716.00
Principal Investigator: A. Marshall McBean
Robert Kane
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 final drafts of activities one and two have been submitted on schedule. Activity three is on schedule and complete. The acute and long-term care services analysis is underway.

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 deliverables, named Activities one and two of this project, found that diabetes care services decreased and the odds of dying increased. However, among patients with multiple chronic conditions as compared to patients with diabetes only, the receipt of these diabetes care services was associated with only half the odds of dying and lower costs to Medicare. The Chronic Condition Warehouse (CCW), also known as the 723 database, and Part D data serve as the data sources for the analytic studies to be conducted under the deliverable named Activity three for this contract. In addition, the contract was modified to add an analysis of acute and long-term care services. Specifically, the cost of major types of acute and long-term care services received by beneficiary groups identified as receiving waivers or State plans services will be examined in 8 states; namely AR, FL, MN, NM, PA, TX, WA, and VT. The modification also includes tracking three groups of costs: Medicaid only, Medicaid expenses for Duals, and Medicare and Medicaid expenses for Duals. Pooled data from the CCW and Medicaid Analytic eXtract (MAX) across years will be used for this analysis. ■

Montana Basic Medicaid for Able-Bodied Adults

Project No: 11-W-00181/08
Project Officer: Kelly Heilman
Period: January 2004 to December 2013
Funding: $ 0.00
Principal Investigator: Mary Dalton
Award: Waiver-Only Project
Awardee: Montana Department of Public Health and Human Services
P.O. Box 4210, 111 North Sanders
Helena, MT 59604-4210

Status: On the basis of the State's July 30, 2009 and August 13, 2010 proposals, CMS approved the extension of the Basic Medicaid Demonstration under authority of section 1115(a) of the Social Security Act (the Act). The Demonstration will continue for the period of December 1, 2010 through December 31, 2013. The new Waiver Mental Health Service Plan (WMHSP) began enrollment on December 1, 2010.

Description: The Montana Basic Medicaid for Able-Bodied Adults (Basic Medicaid) is a statewide section 1115 Demonstration administered by the Montana Department of Public Health and Human Services (the State). The Basic Medicaid program began in 1996, under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM). Under FAIM, Montana provided all mandatory Medicaid benefits and a limited collection of optional services to approximately 8,500 able-bodied adults (aged 21through 64 and neither pregnant nor disabled), who are parents and/or caretaker relatives of dependent children at or below the State Standard of Need (i.e., otherwise eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act). The FAIM welfare reform waiver expired on January 31, 2004, and was replaced (without change) by a section 1115 Medicaid Demonstration, which was approved for the period of February 1, 2004 through January 31, 2009. The Demonstration was continued through a series of Temporary Extensions through November 30, 2010. On January 25, 2008, Montana proposed to renew the Basic Medicaid for Able-Bodied Adults Demonstration for eligible parents and caretaker adults and in subsequent communications proposed to expand eligibility using demonstration savings. On July 30, 2009 and August 13, 2010, the State submitted revised proposals to CMS. Under the revised proposals, Demonstration savings are used to provide Medicaid-like coverage to up to 800 individuals, aged 18 through 64, with incomes at or below 150% FPL, who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia,

bipolar disorder, or major depression, and who would not otherwise be eligible for Medicaid benefits. Prior to enrollment in the section 1115 Demonstration, these individuals received a very limited mental health benefit through enrollment in a State-financed Mental Health Service Plan (MHSP). ■

Mosaic: Iowa Community Integration (ICI) Project

Project No: 1C0CMS030272/01
Project Officer: Pamela Pope
Period: July 2008 to June 2010
Funding: $286,899.00
Principal Investigator: Ann Sexton
Award: Grant
Awardee: Mosaic
7925 SE 32nd Avenue
Runnells, IA 50237

Status: Final reports were received on September 1, 2010. Grant is scheduled to close out by OAGM.

Description: Mosaic is a non-profit organization whose mission is to provide support and advocacy for people who have disabilities so that they may realize wholeness of life. Through a group effort, the Iowa Community Integration (ICI) Project was formed. ICI will serve as a logical step towards achieving full integration of individuals with disabilities throughout Iowa. The main objective of the Iowa Community Integration Project is to create and implement a successfully demonstrated model that will support outplacement and community integration of individuals with developmental disabilities who are currently institutionalized at the Glenwood and Woodward Resource Centers in Iowa. ■

Multi-Disciplinary Investigational Intervention on Reducing Polypharmacy and Enhancing Adherence to Drug Regimens Among Elderly African Americans

Project No: 1I0CMS030458/02
Project Officer: Richard Bragg
Period: September 2009 to September 2011
Funding: $100,000.00
Principal Investigator: Mohsen Bazargan
Award: Grant
Awardee: Charles Drew University of Medicine & Science Dept. of Research/Div. of Grants, Contracts & Compliance
1731 E. 120th Street, Cobb 101
Los Angeles, CA 90059

Status: This research project is a second year continuation project under the Historically Black Colleges and Universities (HBCU) Health Services Research Grant Program.

Description: Excessive and unnecessary use of prescription and over-the-counter medications (polypharmacy) is a major problem and challenge that contributes to increased costs, adverse drug events, poor adherence, inappropriate prescribing, hospitalization, and mortality in the elderly. The study is an outreach program that examines the effects of an educational intervention on reducing excessive and unnecessary use of prescription and over-the-counter medication. The program is aimed at enhancing adherence to drug regimens among low income elderly African Americans with multiple chronic conditions residing in South Central Los Angeles. The specific objective of the study is to evaluate the effectiveness of "an intervention," which includes collaborating with a network of faith based churches under the leadership of the pastor to encourage Medicare beneficiaries to participate; proving study participants with opportunities to periodically meet with trained counselors who will review and educate on medication information; reducing concurrent use of duplicate drugs in doses or frequencies greater than necessary or drug therapy that is not essential for treating or managing a medical problem; and increasing the adherence to physician recommended drug regimens, and increasing the involvement of underserved aged African Americans as informed and active partners in their health care, by improving knowledge of their medications and facilitating better communication with their health care providers. The major objective is twofold: to ultimately reduce the number of emergency hospitalization admissions associated with polypharmacy

and non-adherence to medications and to facilitate better communication between patients and their health care providers. ■

National Implementation of the HHCAHSP Survey

Project No: HHSM-500-2005-00029I/HHSM-500-T0004
Project Officer: Lori Teichman
Period: September 2009 to September 2011
Funding: $1,669,752.00
Principal Investigator: Judith Lynch
Award: Task Order (XRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This project was transferred to Lori Teichman who is now the COTR for the Home Health CAHPS (HHCAHPS) survey. Option year one has been exercised which extended this project through September 14, 2011.

Description: This task order will continue the design and implementation of a coordinated strategy for the national implementation of the Home Health Care CAHPS (HHCAHPS) survey by trained multiple vendors using the standardized HHCAHPS survey questionnaire, identified administrative protocols, and statistical adjustments in order to ensure that final publicly reported data are valid and reliable to permit accurate comparisons of patients' perspectives across home health agencies. CMS anticipates that all home health agencies (HHAs) will contract with a CMS-approved HHCAHPS survey vendor. ■

Nevada Health Insurance Flexibility and Accountability (HIFA) Waiver Demonstration

Project No: 21-W-00053/09
Project Officer: Robert Nelb
Period: November 2006 to November 2011
Funding: $ 0.00
Principal Investigator: Nova Peek
Award: Waiver-Only Project
Awardee: Division of Health Care Financing and Policy
100 East William Street, Suite 200
Carson City, NV 89701

Status: As of October 31, 2010, 120 individuals were enrolled in this demonstration.

Description: This demonstration expands coverage to pregnant women with family incomes above 133% FPL, up to and including 185% FPL, through direct coverage. The demonstration also expands coverage to parents, caretaker relatives and legal guardians of Medicaid or CHIP children with family incomes below 200% FPL through employer sponsored insurance. ■

New Jersey Family Coverage Under SCHIP for Families and Pregnant Women

Project No: 11-W-00164/02 and 21-W-00003/02-01
Project Officer: Stacey Green
Period: January 2001 to September 2011
Funding: $ 0.00
Principal Investigator: John Guhl
Award: Waiver-Only Project
Awardee: Department of Human Services, Division of Medical Assistance & Health Services
7 Quakerbridge Plaza
Trenton, NJ 08625-0712

Status: Coverage for parents and caretaker relatives under the demonstration was extended through September 30, 2011, under section 2111(b)(1)(B) of the Act, which was enacted by section 112 of the Child Health Insurance Reauthorization Act of 2009. Coverage for pregnant women under the demonstration ended and was replaced by coverage under the title XXI State plan, effective April 1, 2009. As of December 31, 2009 there were 173,517 parents enrolled in the demonstration.

Description: This demonstration expands health care coverage to uninsured custodial parents and caretaker relatives of Medicaid and SCHIP children with family incomes up to and including 200% FPL and to pregnant women who are uninsured and not covered by Medicaid, with family incomes above 185% up to and including 200% FPL. ■

New Mexico Family Planning Expansion

Project No: 11-W-00111/06
Project Officer: Rebecca Burch Mack
Period: May 1997 to January 2011
Funding: $ 0.00
Principal Investigator: Julie Weinberg
Award: Waiver-Only Project
Awardee: New Mexico Human Services Department, Medical Assistance Division
228 East Palace Avenue, La Villa Revera Bldg., 1st Floor
Santa Fe, NM 87501

Status: On August 25, 2009, the State requested a three year extension of the Demonstration; the request is pending. The Demonstration is currently operating under temporary extension through January 31, 2011 as the State makes a final decision on whether to continue with its request to renew the Demonstration or pursue the State plan family planning eligibility option. As of September 30, 2010, 29,369 individuals were enrolled in the Demonstration.

Description: This demonstration provides family planning services to uninsured women of childbearing age (18-50) who are not otherwise eligible for Medicaid, SCHIP, Medicare or the State's HIFA amendment demonstration and who have family income at or below 185% FPL. ■

New Mexico State Coverage Initiative

Project No: 11-W-00146/06 and 21-W-00012/06
Project Officer: Andrea Casart
Period: August 2002 to September 2011
Funding: $ 0.00
Principal Investigator: Julie Weinberg
Award: Waiver-Only Project
Awardee: Department of Human Services, Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

Status: Effective January 1, 2010, nonpregnant childless adults who had been receiving coverage under this demonstration were transitioned to a new Medicaid demonstration (State Coverage Insurance Demonstration, 11-W-00247/6). Parents remain in this demonstration and the demonstration for them was extended through September 30, 2011, under Section 2111(b)(1)(B) of the Act which was enacted by Section 112 of CHIPRA.

Description: This demonstration provides coverage to uninsured parents of Medicaid and SCHIP-eligible children with incomes from 27% FPL up to 200% FPL. Employers and employees are required to contribute to the cost of coverage. ■

New Mexico State Coverage Insurance

Project No: 11-W-00247/06
Project Officer: Mark Pahl
Period: December 2009 to September 2014
Funding: $ 0.00
Principal Investigator: Julie Weinberg
Award: Waiver-Only Project
Awardee: New Mexico Human Services Department, Medical Assistance Division
228 East Palace Avenue, La Villa Revera Bldg., 1st Floor
Santa Fe, NM 87501

Status: As of March 31, 2010, 35,259 individuals were enrolled in the demonstration.

Description: This demonstration provides title XIX funded coverage to uninsured non-pregnant childless adults up to 200% FPL. Employers and employees are required to contribute to the cost of coverage. Prior to January 1, 2010, the population served by this demonstration received identical benefits funded through title XXI under the State Coverage Initiative Demonstration (11-W-00146/6 and 21-W-00012/6). Section 2111(a) of the Social Security Act, as enacted by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009, ended title XXI funding for childless adults' coverage, and provided the opportunity for the State to request this Medicaid demonstration to continue coverage for the affected childless adult population using title XIX funds. ■

New Mexico Title XXI SCHIP

Project No: 11-W-00124/06
Project Officer: Andrea Casart
Period: January 1999 to December 2013
Funding: $ 0.00
Principal Investigator: Julie Weinberg
Award: Waiver-Only Project
Awardee: Department of Human Services, Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

Status: On December 16, 2010, CMS approved a three-year extension for this demonstration, through December 31, 2013.

Description: This demonstration permits the State to impose a six month waiting period for the demonstration population, which is composed of uninsured children from birth through age 18, from 185% FPL up to, but not including, 235% FPL. ■

New York Federal-State Health Reform Partnership

Project No: 11-W-00234/02
Project Officer: Camille Dobson
Period: September 2006 to September 2011
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Room 1466, Corning Tower Building
Albany, NY 12237

Status: The State submitted a request for a three year extension to the Demonstration under section 1115(e) of the Act on September 30, 2010.

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. ■

New York Partnership Plan

Project No: 11-W-00114/02
Project Officer: Camille Dobson
Period: July 1997 to January 2011
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Room 1466, Corning Tower Building
Albany, NY 12237

Status: The State submitted a formal extension application on March 31, 2009. The demonstration expired on September 30, 2009, and has been continued through a series of temporary extensions under the same terms and conditions, while discussions continue over a possible longer extension.

Description: The Partnership Plan Demonstration was approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations. In 2001, the Family Health Plus (FHPlus) 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. ■

North Carolina Family Planning

Project No: 11-W-00182/04
Project Officer: Juliana Sharp
Period: November 2004 to January 2011
Funding: $ 0.00
Principal Investigator: Craigan Gray
Award: Waiver-Only Project
Awardee: Division of Medical Assistance, Department of Health and Human Services
1985 Umstead Drive, 2517 Mail Service Center
Raleigh, NC 27699-2517

Status: On March 31, 2010, the State requested a three year extension of the Demonstration which was set to expire on September 30, 2010; the request is pending. The Demonstration is currently operating under a temporary extension set to expire on March 31, 2011. As of March 30, 2010, approximately 76,535 individuals were enrolled in the Demonstration.

Description: This demonstration provides coverage for family planning services for uninsured men and women over the age of 18 with incomes at or below 185% FPL who are not otherwise eligible for any other Medicaid program. ■

Nursing Home Value-Based Purchasing Demonstration

Project No: HHSM-500-2005-00018I/0001
Project Officer: Ronald Lambert
Period: September 2006 to September 2013
Funding: $2,755,000.00
Principal Investigator: Alan White
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: This three year demonstration began July 1, 2009 in three states: Arizona, New York, and Wisconsin. The following numbers of nursing homes were selected to participate at the beginning of the demonstration: Arizona - 41, New York - 79, Wisconsin - 62. CMS is collecting payroll data from participants each quarter to assess performance in the staffing domain, and will assess the other three domains using administrative data. CMS has selected a nursing home comparison group in each state to calculate the Medicare savings under the demonstration. Annual performance payments will be made based on the estimated Medicare savings. The savings calculation for the first year of the demonstration is expected to occur in the summer of 2011.

Description: The Nursing Home Value-Based Purchasing (NHVBP) demonstration is the CMS "pay-for-performance" initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing homes. Under this demonstration, CMS will provide financial incentives to nursing homes that demonstrate high standards for providing quality care. CMS will assess quality performance on four domains: nurse staffing, avoidable hospitalizations, resident outcomes, and state health inspection surveys. The demonstration will be financed from reductions in Medicare expenditures, primarily from reductions in hospitalizations due to improved quality. We will include all Medicare beneficiaries who reside in a participating nursing home (i.e., those in a Part A SNF stay as well as those who receive only Part B benefits), many of whom are dually eligible for Medicare and Medicaid. ■

Nutrition and Exercise Start Today (NEST): Obesity prevention for rural Hispanic families

Project No: 1H0CMS030457/02
Project Officer: Richard Bragg
Period: September 2009 to September 2011
Funding: $100,000.00
Principal Investigator: Deborah Parra-Medina
Jane Youngers
Award: Grant
Awardee: University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78229-3900

Status: This is a second year continuation grant under the Hispanic Health Services Research Grant Program.

Description: A well documented argument has been established indicating that overweight children and childhood obesity have reached epidemic proportions and are major public health problems nationally and globally. It is further argued that currently about 25 million U.S. children and adolescents are overweight or obese, with children from families of low socio-economic status

experiencing a disproportionate burden. The purpose of the study is to develop, implement, and evaluate a comprehensive family-based intervention targeting Hispanic children (age 5-14) and their parent(s) in a rural pediatric clinic. This goal for the project is to reduce childhood overweight and obesity. The objectives for the study are the following: 1) Recruit 200 overweight and obese Hispanic children and their parents from a rural children's clinic, the New Braunfels Pediatric Associates in New Braunfels, Texas. 2) Develop and implement a family-based educational intervention focused on healthy lifestyles. 3) Assess the impact of the educational intervention on children's weight maintenance, sedentary behavior, consumption of sweetened beverages, and fasting insulin and serum glucose levels. This is an educational intervention design. The study is targeting a rural community in New Braunfels, Comal County, Texas, with a population of approximately 51,000 individuals, of which 33% are Hispanic. ■

Oklahoma Family Planning

Project No: 11-W-00177/06
Project Officer: Rebecca Burch Mack
Period: November 2004 to January 2011
Funding: $ 0.00
Principal Investigator: Mike Fogarty
Award: Waiver-Only Project
Awardee: Oklahoma, Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Status: On November 12, 2009, the State requested a three year extension of the Demonstration; the request is pending. The Demonstration is currently operating under temporary extension through January 31, 2011, as the State makes a final decision on whether to continue with its request to renew the Demonstration or pursue the State plan family planning eligibility option. As of September 30, 2010, 27,733 individuals were enrolled in the Demonstration.

Description: The demonstration allows the State to extend Medicaid eligibility for family planning services to uninsured women age 19 and older, regardless of pregnancy history, with family income at or below 185% FPL, who are otherwise ineligible for Medicaid benefits, including women who gain eligibility for title XIX reproductive health services due to pregnancy, but whose eligibility ends 60 days postpartum, and to uninsured men, ages 19 and older, at or below 185% FPL, regardless of paternity history. ■

Oklahoma SoonerCare Demonstration

Project No: 11-W-00048/06
Project Officer: Mark Pahl
Period: October 1995 to December 2012
Funding: $ 0.00
Principal Investigator: Mike Fogarty
Award: Waiver-Only Project
Awardee: Oklahoma, Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Status: As of June 30, 2010, 481,076 individuals are enrolled in the demonstration.

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. In January 2009, the demonstration was amended to change the partially capitated delivery system to a Primary Care Case Management Model; expand the size of employers who can participate in the Employer Sponsored Insurance (ESI) program; and add full-time college students through age 22 as an expansion population. 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. ■

Orange County Government Primary Care Access Network (PCAN)

Project No: 1C0CMS030273/01
Project Officer: Pamela Pope
Period: July 2008 to December 2010
Funding: $306,549.00
Principal Investigator: Pete Clarke
Award: Grant
Awardee: Orange County Board of County Commissioners
2100 East Michigan Street
Orlando, FL 32806

Status: The financial status report has been received for the period ending June 30, 2010. Grantee has not submitted additional requests for further extension. Grant is scheduled for close out after final report is received.

Description: The objective of this project is to improve access to care for more than 90,000 uninsured patients in Orange County by implementing an electronic information exchange and network wide eligibility system. Under Orange County Government leadership the Primary Care Access Network (PCAN), a partnership of 20 public and private safety-net providers and community organizations, has created a high quality comprehensive health care delivery system. By linking and expanding all levels of care, to include primary, specialty, behavioral health, dental, and pharmacy services, they have improved access to care for more than 90,000 uninsured patients on Orange County. ■

ORDI Demonstration Implementation, Monitoring and Evaluation

Project No: HHSM-500-2006-00005I/HHSM-500-T0002
Project Officer: Lawrence Caton
Period: September 2010 to September 2011
Funding: $395,564.00
Principal Investigator: C. William Wrightson
Award: Task Order
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The project is underway.

Description: Pursuant to the authority of Section 402 of PL90-248 (42 U.S.C. 1395b-1) the secretary, Department of Health and Human Services is authorized to waive requirements in the Title XVIII related to reimbursement and payment. Furthermore, the secretary is authorized to develop and implement demonstrations for the purpose of improving the efficiency and effectiveness by seeking new methods of payment or expanding the use of new procedures. The secretary is required to evaluate whether quality of care and/or satisfaction improve for targeted beneficiaries with threshold conditions that Medicare expenditures for demonstrations and budget neutral demonstrations meet contractual requirements. This requires expert monitoring and oversight throughout the demonstrations. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing and monitoring demonstration projects undertaken across the United States. In order to implement demonstrations, CMS must have a support contract in place to assist in Medicare program development and monitoring of industry partners who participate in these demonstrations. ■

Oregon Family Planning

Project No: 11-W-00142/00
Project Officer: Juliana Sharp
Period: October 1998 to October 2012
Funding: $ 0.00
Principal Investigator: Judy Mohr-Peterson
Award: Waiver-Only Project
Awardee: Department of Health and Human Services-Office of Medical Assistance Programs
500 Summer Street, NE E49
Salem, OR 97301-1079

Status: On March 26, 2010, CMS approved a three-year extension of the Demonstration which is now set to expire on October 31, 2012. As of September 30, 2010, 78,973 individuals were enrolled in the Demonstration.

Description: The purpose of the demonstration is to provide family planning services to uninsured men and women of childbearing age who are not otherwise eligible for Medicaid or CHIP, and who have family income at or below 250% FPL. ■

Oregon Health Plan 2

Project No: 11-W-00160/0 and 21-W-00013/0
Project Officer: Steven Rubio
Period: October 2002 to October 2013
Funding: $ 0.00
Principal Investigator: Judy Mohr-Peterson
Award: Waiver-Only Project
Awardee: Oregon, Department of Human Services
500 Summer St, NE - E10
Salem, OR 97301-1076

Status: On October 22, 2009 the State of Oregon submitted its application and its formal request to the Centers for Medicare and Medicaid Services (CMS) requesting an extension of the State's section 1115(a) Medicaid demonstration, known as the Oregon Health Plan (OHP), as a section 1115(e) demonstration. This demonstration was approved for the period November 1, 2010, through October 31, 2013.

Description: The Oregon Health Plan (OHP) Demonstration allows the State to uses savings from two sources (Medicaid managed care and a restructured benefit package based on a prioritized list of services) to provide Medicaid-funded coverage to additional low-income individuals who otherwise would not be eligible for Medicaid. It also provides an option for CHIP-eligible children to receive a premium assistance benefit instead of CHIP coverage. Four distinct benefit packages are offered to different categories of individuals participating in the demonstration. OHP Plus is the broadest benefit package, and is provided to Medicaid State plan populations. OHP Standard, which is less comprehensive in coverage than OHP Plus, is provided to expansion parents and childless adults/couples up to 100% FPL. Both OHP Plus and OHP Standard are governed by the prioritized list of services, which is updated every two years by the Oregon Health Services Commission. The third benefit package is the Family Health Insurance Assistance Program (FHIAP), which provides premium assistance for the purchase of employer-based or individual private health insurance coverage. OHP participants who are eligible for OHP Plus or OHP Standard (including children eligible for the State's Medicaid expansion CHIP program) can elect to receive the FHIAP benefit instead. FHIAP is the only benefit available to expansion parents and childless adults/couples between 100% and 185% FPL. Finally, children with incomes between 200% and 300% FPL who are eligible for CHIP can elect to receive a subsidy for the purchase of employer-sponsored insurance under the Healthy Kids ESI program. ■

Payment Development, Implementation Support, and Financial Monitoring for the Care Management of High Cost Beneficiaries Demonstration

Project No: 500-01-0033/0003
Project Officer: Lawrence Caton
Period: May 2005 to January 2011
Funding: $3,223,338.00
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 funding was increased and will cover payment for the contractor's performance of work through December 31, 2009. The balance will be incrementally funded as funds become available. The project was extended through January 31, 2011.

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 (CMHCB) demonstration. 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 six programs, yielding 80,000 to 120,000 beneficiaries for ongoing analysis. ■

Payment Development, Implementation, and Monitoring for Disease Management Demonstrations

Project No: 500-00-0036/0002
Project Officer: Juliana Tiongson
Period: September 2004 to August 2010
Funding: $1,383,158.00
Principal Investigator: C. William Wrightson
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: This contract ended as scheduled on August 31, 2010.

Description: The purpose of this task order is to provide support to the Centers for Medicare & Medicaid Services (CMS) in implementing and monitoring demonstration 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 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, Data Management, Implementation, and Monitoring Support for the Medicare Care Management Performance Demonstration

Project No: 500-00-0036/0003
Project Officer: Jody Blatt
Period: September 2004 to September 2011
Funding: $1,777,855.00
Principal Investigator: Kerry Moroz
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The demonstration is operational. The period of performance was revised to include a two year extension. Approximately 650 small to medium sized physician practices are participating.

Description: This three 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 is being 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. ■

Pennsylvania Family Planning

Project No: 11-W-00235/03
Project Officer: Juliana Sharp
Period: May 2007 to June 2012
Funding: $ 0.00
Principal Investigator: Michael Nardone
Award: Waiver-Only Project
Awardee: Pennsylvania, Department of Public Welfare
P. O. Box 2675
Harrisburg, PA 17105-2675

Status: As of September 30, 2010, 47,191 individuals were enrolled in the Demonstration.

Description: The Pennsylvania Family Planning Demonstration offers eligibility for family planning services to women from age 18 to 44 that have family income below 185% FPL and women who have family income up to 185% FPL who lost Medicaid eligibility at the end of 60 days post-partum. ■

Performance Monitoring of Voluntary Chronic Care Improvement/Medicare Health Support Under Traditional Fee-For-Service Medicare.

Project No: 500-00-0033/0008
Project Officer: Pamela Cheetham
Louisa Rink
Period: February 2005 to November 2009
Funding: $6,059,875.00
Principal Investigator: Sue Felt-Lisk
Don Lara
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The last routine performance monitoring quarterly reports were delivered in January 2009. Program operations for phase one of this pilot project concluded in August 2008. The last contractor/CMS assessment of the degree to which MHSO self-selected clinical performance targets were achieved by each Medicare Health Support Organizations was delivered in September 2009. The project completed on November 30, 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 management 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 who actively participated in MHS). This data tracks the efforts of the individual MHSOs and provides information to the independent evaluator. Comparative data will help 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: GS-10F-0244S/HHSM-500-2006-00100G
Project Officer: Claudia Brown
Period: August 2006 to August 2011
Funding: $4,174,774.00
Principal Investigator: Sheila Scott
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 Systems Change Grants (RCSC) grants and increase the expected attendance at the Medicaid Infrastructure Grant (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. The contractor has had difficulty keeping staff and the turnover has caused delays in completing tasks. The contractor has been put on notice of the requirement to fulfill their obligations under the contract. By late December of 2008, all positions were filled. In 2009, the funding was increased by $38,020 and a new Project Officer was assigned to the contract.

Description: The purpose of this task order is to provide support to the Centers for Medicare and Medicaid Services' (CMS's) 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 grants are:

- Medicaid Infrastructure Grants (MIG);
- Demonstration to Maintain Independence & Employment (DMIE) Grants; and
- Real Choice Systems Change Grants (RCSC) - Fiscal Years 2002-2006. ■

Post Acute Care Payment Reform Demonstration: Project Implementation and Analysis.

Project No: HHSM-500-2005-00029I/0005
Project Officer: Shannon Flood
Period: February 2007 to June 2011
Funding: $8,499,203.00
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 II of development. Relevant data collection instruments were developed, tested, and implemented via an online application. Data collection has concluded for the project. Current activities include analysis and report writing.

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 data from beneficiaries treated in acute care hospitals and four types of PAC providers: Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Skilled Nursing Facilities, and Home Health Agencies. Work on the PAC-PRD is divided into three contracts. This task order comprises the third contract, to provide implementation and analysis of the demonstration. This task 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 data are 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 recommendations, predicting resource utilization, predicting discharge placement, and predicting outcomes. ■

Post-Acute Care: Patient Assessment Instrument Development

Project No: HHSM-500-2005-00029I/0004
Project Officer: Judith Tobin
Period: November 2006 to March 2011
Funding: $6,473,642.00
Principal Investigator: Barbara Gage
Richard Strowd
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The CARE (Continuity Assessment Record & Evaluation) data set has been designed, developed, and tested in a three year Post Acute Care Payment Reform Demonstration, consistent with requirements under the 2005 Deficit Reduction Act (DRA). To date, over 38,000 CARE assessments have been completed by hospitals and PAC providers and submitted to CMS. The contractor and the Office of Research, Development, and Information (ORDI) are currently analyzing the findings and will make recommendations to changes in PAC payment models in early 2011.

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. ■

Preadmission Screening and Resident Review (PASRR) Technical Assistance for States

Project No: HHSM-500-2006-00006I/HHSM-500-T0001
Project Officer: Angela Taube
Period: September 2009 to September 2011
Funding: $736,424.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: This project has been extended through September, 2011.

Description: As part of the Omnibus Budget Reconciliation Act (OBRA) enacted in 1987, Congress developed the Preadmission Screening and Resident Review (PASRR) program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities. Federal law mandates that Medicaid-certified nursing facilities (NF) may not admit an applicant with serious mental illness (MI), mental retardation (MR), or a related condition, unless the individual is properly screened, thoroughly evaluated, found to be appropriate for NF placement, and will receive all specialized services necessary to meet the individual's unique MI/MR needs. States are required to have a PASRR program in order to screen all NF applicants to Medicaid certified NFs (regardless of payer source) for possible MI/MR, and if necessary to further evaluate them according to certain minimum requirements. The state uses the evaluation to determine, prior to admission, whether NF placement is appropriate for the individual, and whether the individual requires specialized services for MI/MR. As a condition of the Centers for Medicare and Medicaid Services's (CMS's) approval of a Medicaid state plan, the state must operate a preadmission screening program that compiles with federal regulations. Additionally, the PASRR regulation requires resident reviews when there is a significant change in a NF resident's physical or mental condition. All applicants to Medicaid certified NFs (regardless of payer source) receive a Level I PASRR screen to identify possible MI/MR. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have MI/MR are referred for a Level II PASRR evaluation. ■

Prescription Assistance Program

Project No: 1C0CMS030268/01
Project Officer: Pamela Pope
Period: July 2008 to December 2010
Funding: $ 95,305.00
Principal Investigator: Maximo Martinez
Award: Grant
Awardee: Gadsden Community Health Council, Inc.
216 North Adams Street
Quincy, FL 32351

Status: This project was scheduled to end on December 31, 2010. No other request for an extension have been received, OAGM will schedule for close out after the final reports are received.

Description: The Prescription Assistance Program under the Gadsden Community Health Council, Inc., helps patients with a gross income of 200% FPL or lower to receive prescription medications at little or no out-of-pocket cost. The intent of this program is to help those citizens that otherwise could not afford their medications. The results and benefits of this program are twofold. First, citizens of Gadsden County are able to receive their medications that they are prescribed and are able to follow the instructions of their physicians. Second, having access to their medications is vital to their health and wellbeing. In turn Gadsden Community Health Council is helping to create a healthier Gadsden County. ■

Program of All-Inclusive Care for the Elderly (PACE)

Project No: 1C0CMS030444/01
Project Officer: Michael Henesch
Period: August 2009 to January 2012
Funding: $238,000.00
Principal Investigator: George Searcy
Award: Grant
Awardee: Hope Through Housing Foundation
9065 Haven Avenue, Suite 100
Rancho Cucamonga, CA 91730

Status: The project is underway and the grantee is consulting with experts to assist in establishing a PACE center.

Description: This program will establish a provider-based Medicare and Medicaid managed care program that integrates medical, social, nutritional, rehabilitative, and support services for frail elderly in Southern California. ■

Programming Support for Utilization and Cost Studies Using the SEER-Medicare Database

Project No: 500-02-0006/0004
Project Officer: Gerald Riley
Period: September 2004 to February 2010
Funding: $199,987.00
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 updated the SEER-Medicare linked database to include SEER cancer cases diagnosed through 2005. Beginning in 2010, NCI assumed responsibility for contracting for SEER-Medicare programming support.

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. ■

Project Access Community Health Partnership

Project No: 1C0CMS030447/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $190,000.00
Principal Investigator: Rae Bond
Award: Grant
Awardee: Medical Foundation of Chattanooga
1917 E. Third Street
Chattanooga, TN 37404

Status: This project was scheduled to end on January 30, 2011. No other requests for an extension have been received, OAGM will schedule for close out after final reports are received.

Description: This program will provide health care access to low-income uninsured residents of Hamilton County. It brings together medical schools, community clinics, doctors, hospitals, and many other partners all for the common goal of improving the health and well-being of the people of Chattanooga and Hamilton County. ■

Public Reporting of Part D

Project No: HHSM-500-2006-00006I/0003
Project Officer: Julie Gover
Period: August 2006 to December 2009
Funding: $791,839.00
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 incorporated by reference and made a part of the task order in September 2007. The period of performance was extended, with the extension funded in the amount of $134,457, and two option years were added. The option year for January 1, 2010 – December 31, 2010 was not exercised. This LIS project was combined with a Best Available Evidence (BAE) policy project and rebid. Acumen was awarded that contract, entitled "Compliance with Best Available Evidence Policy and Evaluation of Part D Sponsors' Low-Income Subsidy Match Rate," task order HHSM-500-2009-00107G.

Description: This task order will develop the method to collect the Low Income Subsidy (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 government task leader 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/0001
Project Officer: David Miranda
Period: July 2006 to September 2011
Funding: $3,001,720.00
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," the contractor's responses to CMS technical questions, and the contractor's technical proposal entitled "Public Reporting of Cost & Volume: Website Audience Testing" 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 Implementation and Analysis

Project No: HHSM-500-2005-00022I/HHSM-500-T0001
Project Officer: Susan Joslin
Period: September 2009 to September 2011
Funding: $1,866,226.00
Principal Investigator: Martha Powell
Award: Task Order (MRAD)
Awardee: University of Colorado
PO Box 2393
Denver , CO 08543

Status: The production software was released in November 2010. The contract is currently operating under Option Year 1. During this option year the contractor will develop additional components of the survey process that will be incorporated into the QIS with the next opportunity for production software updates.

Description: This task order is for work that continues the development of the Quality Indicator Survey (QIS), which has been under development through a current contract with the University of Colorado. QIS is a computer-driven, expert system that is entirely replacing the current (traditional) paper-based survey process. Now, with the completion of the demonstration phase, CMS is moving forward with a gradual national implementation of the QIS. Due to the extensive training needed by each state and federal surveyor, implementation is occurring in a staged fashion, state by state, as funds become available to have our training contractor train additional surveyors. Simultaneously, CMS is continuing with the current contractor, the University of Colorado, to develop additional features of the QIS including other survey types, such as post survey revisit, as well as a new federal monitoring system. The installation of these new features into the CMS data system requires a close collaboration between the University of Colorado and the CMS data contractor. The QIS manual resides on the University of Colorado's website and is accessible at http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/hcpr/qis/Pages/default.aspx. This task order also funds new work to add refinements to the QIS E-forms, procedures, and software. ■

Rationalize Graduate Medical Education Funding

Project No: 18-C-91117/08
Project Officer: Siddhartha Mazumdar
Period: February 2000 to June 2010
Funding: $839,875.00
Principal Investigator: David Squire
Award: Cooperative Agreement
Awardee: Medical Education Council
230 South 500 East, Suite 550
Salt Lake City, UT 84102-2062

Status: This demonstration ended June 30, 2010, as far as the CMS redistribution of the Medicare direct GME funds to the Utah Medical Education Council.

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

Recovery - Comparative Effectiveness Research (CER) Data Infrastructure Medicaid Analytic eXtract (MAX) Long-Term Care-Assessment (LTC-A) File

Project No: HHSM-500-2006-00005I/HHSM-500-T0001
Project Officer: Negussie Tilahun
Period: April 2010 to August 2013
Funding: $528,288.00
Principal Investigator: Franklin Eppig
John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale,VA 22003

Status: The project is underway.

Description: The purpose of this contract is to produce person level data files and related information to support Comparative Effectiveness Research (CER) that is funded by the American Recovery and Reinvestment Act of 2009 (ARRA). As a component of the ARRA, CMS has been approved by the Department of Health and Human Services to produce and enhance the Medicaid Analytic eXtract file (MAX). Work on the MAX is divided into three contracts. The work in this contract will develop a research file that incorporates key administrative assessment data from the Minimum Data Set (MDS) for nursing facilities, data from the Outcome and Assessment Information Set (OASIS) for home health agencies, and selected On-line Survey and Certification Assessment Reporting (OSCAR) data and link it to Medicare and Medicaid administrative data for Medicaid, dual-eligible and private pay patients (MDS beneficiaries only). This file will be known as the Long-Term Care Assessment file (LTC-A). A wide range of beneficiary and provider information will be linked with the MAX system of files and the Medicare Base Summary Files (BASF) from the CMS Chronic Condition Warehouse (CCW). CMS believes that this effort will greatly enhance CER studies pertaining to long-term care and post-acute services by compiling this information in one file. This project will include data for the years 1999-2011. Tasks include the development of a file design report and work plan, a pilot test of the LTC-A data file using data for calendar year 2006. The final LTC-A production could either cover the entire year or subset of the study period given the current level of effort. If it is determined to use a subset of the study period, the contractor will justify the sample years that will be selected for data production. The American Recovery and Reinvestment Act of 2009 (ARRA) provided funds for Comparative Effectiveness Research allocated for the Department of Health and Human Services (HHS). ■

Recruitment of a Primary Care Workforce for New Hampshire

Project No: 1C0CMS030441/01
Project Officer: Pamela Pope
Period: August 2009 to May 2011
Funding: $755,000.00
Principal Investigator: Stephanie Pagliuca
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: Status reports have been received. The file is current.

Description: This program will recruit and retain primary care health professionals for New Hampshire, especially to community health centers and practices located in underserved and rural areas of the state. The resources from this project will allow health centers to continue to invest in increasing recruitment costs such as: Locum Tenens Coverage to maintain the level of primary health care services and reduce burnout of existing providers, recruitment placement fees, marketing and advertising costs, and costs of travel for candidate site visits and interviews. In addition to providing assistance with the health center's direct cost to recruit and retain health professionals, the New Hampshire Recruitment Center will use the resources from this project to boost outreach to primary care providers in practice and in training to increase the pool of primary care health professionals interested in working in New Hampshire. ■

Regional Home Health Intermediary Verification Protocol (eROVER)

Project No: 500-00-0032/0010
Project Officer: Nancy Moore
Randy Throndset
Ann Meadow
Period: September 2008 to July 2010
Funding: $1,948,749.00
Principal Investigator: Henry Goldberg
Alan White
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project closed on July 31, 2010.

Description: The eROVER is a software package that was developed for Regional Home Health Intermediaries (RHHIs) to assess the accuracy of Home Health Resource Groups (HHRG) by verifying the accuracy of the underlying Outcome and Assessment Information Set (OASIS) data. The eROVER software allows agency OASIS responses to be electronically imported into the program. ■

Research Data Assistance Center (ResDAC)

Project No: HHSM-500-2005-00027I/0003
Project Officer: Linh Kennell
Period: September 2008 to September 2013
Funding: $5,418,443.00
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 project has been modified to increase the number of workshops/training, the help desk support services, and the website resources for Comparative Effectiveness Research.

Description: This project assists researchers who are not familiar with the data available at CMS. ResDAC staff members describe CMS data and help researchers with the process of gaining an approved Data Use Agreement. 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 project has been awarded ARRA funds. ■

Research Data Distribution Center (RDDC)

Project No: HHSM-500-2008-00027C
Project Officer: Michelle Ruff
Period: September 2008 to December 2010
Funding: $3,008,810.00
Principal Investigator: Todd Goeldner
Award: Contract
Awardee: Buccaneer Computer Systems
6799 Kennedy Road, Suite J
Warrenton ,VA 20187

Status: An extension for this contract is pending.

Description: The Research Data Distribution Center (RDDC) disseminates Medicare and Medicaid data to public and private researchers. Since most of RDDC's customers are the research community, it was agreed by CMS senior staff that ORDI would take over the management activities of the RDDC. (Currently the RDDC is managed by the Office of Information Services.) Over the next two years, it is ORDI's intent to closely coordinate the RDDC and Chronic Care Warehouse (CCW) activities and develop a single data dissemination infrastructure. After this contractor has demonstrated that they can successfully handle the current RDDC workload, we intend to start transferring some of the CCW databases to the RDDC. Once the period of performance for these two contracts has ended, the plan is to solicit a new contract to combine the Medicare and Medicaid data dissemination activities of the RDDC and the CCW into a single contract with a single database. The contractors operations shall be funded solely through user fees collected from paying customers. CMS reserves the right to request that the RDDC process data from non-paying customers such as Congressional entities. These requests shall be funded from CMS's administrative budget. ■

Revision of Medicare Wage Index

Project No: HHSM-500-2006-00006I/0011
Project Officer: Craig Caplan
Period: February 2008 to August 2012
Funding: $1,335,415.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The work under this contract is being released in a final report that has multiple parts. The Final Report Part I, which examined the data used in MedPAC's approach, was released in May 2009. Part II of the Final Report, which analyzed MedPAC's approach to blending and smoothing, was released in March 2010. As a follow up to its analysis of MedPAC's approach, the contractor is in the process of developing its own recommended approach to defining Medicare wage areas. A report on the proof of concept of the contractor's approach is due in the spring of 2011. The final project report is due August 2012. The funding for this project was increased by $499,816 from $835,599 to $1,335,415. The period of performance end date has been extended by fifteen months to August 11, 2012.

Description: Section 106 of the Tax Relief and Health Care Act of 2006 (TRHCA) required MedPAC to submit a report on revision of the hospital wage index by June 30, 2007, including recommendations on alternatives for computing the wage index. Section 106b requires that CMS take account of MedPAC's recommendations and consider nine specific aspects of the wage index:

- the problems associated with the definition of labor markets for purposes of wage index adjustment,
- the modification or elimination of geographic reclassifications and other adjustments,
- the use of Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved,
- minimizing the variations in wage index adjustments between and within Metropolitan Statistical Areas and Statewide rural areas,
- the feasibility of applying all components of the proposal to other settings, including home health agencies and skilled nursing facilities,
- methods to minimize the volatility of wage index adjustments, while maintaining the principle of budget neutrality in applying such adjustments,
- the effect that the implementation of the proposal would have on health care providers and on each region of the country,
- methods for implementing the proposal, including methods to phase-in such implementation,
- the issues relating to occupational mix, such as staffing practices and any evidence on the effect on quality of care and patient safety and any recommendations for alternative calculations.

The purpose of this task order is to assist CMS in evaluating MedPAC's revisions to the hospital wage index and MedPAC's recommendations regarding implementation of the MedPAC hospital compensation index. ■

Rhode Island Global Consumer Choice Demonstration

Project No: 11-W-00242/01
Project Officer: Angela Garner
Period: January 2009 to December 2013
Funding: $ 0.00
Principal Investigator: Miguel Negron-Rivera
Award: Waiver-Only Project
Awardee: Rhode Island, Division of Health Care Quality, Department of Human Services
600 New London Avenue
Cranston, RI 02920

Status: As of October 2010, 122,522 Medicaid State plan eligibles and 11,500 demonstration eligibles were enrolled in the Rhode Island Global Consumer Choice Demonstration.

Description: Rhode Island will operate its entire Medicaid program under a single Section 1115 Demonstration. All Medicaid funded services on the continuum of care – including preventative care in the home and community, care in high-intensity hospital settings, long-term, and end-of life-care – will be organized, financed, and delivered through the Demonstration. The State's currently operating waivers and demonstrations will be terminated and the services will instead be furnished through this Global Consumer Choice section 1115 demonstration (including Rhode Island's section 1115 RIte Care and RIte Share programs for children and families, the 1915(b) Dental Waiver, and all of its Section 1915(c) home and community based Services waivers). The Global Consumer Choice Demonstration provides for administrative flexibility combined with a potential to rebalance the long-term care system, which will allow individuals to remain in the community to receive their care. o Rhode Island will have the flexibility to change program elements expeditiously using a new administrative process. However, certain modifications will need CMS approval before implementation. o Under the Demonstration, the State will use a revised level of care criteria and expects to allow more individuals to remain in community settings. ■

Rural Community Hospital Demonstration

Project No: -
Project Officer: Siddhartha Mazumdar
Period: October 2004 to December 2016
Funding: $ 0.00
Award: Waiver-Only Project

Status: Eight hospitals are still participating in the demonstration. The ACA provision grants the hospitals that completed the initially mandated five year period an automatic extension for another five years, and allows the selection of additional hospitals to participate for a five year period with the limit that no more than 30 hospitals be allowed to participate in total. Since eight hospitals are currently in the demonstration, a maximum of 22 additional could be selected to participate under a new solicitation, released in August 2010.

Description: This demonstration allows selected rural hospitals to benefit from a modified cost reimbursement structure. An eligible hospital must be located in a rural area (as determined by Medicare law for hospital payment), has fewer than 51 acute care beds, makes available 24-hour emergency room services, and is not eligible for Critical Hospital designation. ■

Rural Hospice Demonstration: Quality Assurance Metrics Implementation Support

Project No: HHSM-500-2005-00034C
Project Officer: Cindy Massuda
Period: September 2005 to September 2010
Funding: $472,444.00
Principal Investigator: Susan Lorentz
Award: Contract
Awardee: HCD International, Inc.
4390 Parliament Place
Lanham, MD 20706-1808

Status: The Rural Hospice Demonstration ended September 28, 2010. It had significant lessons learned. The demonstration showed that the hospices were able to care for all patients appropriately under the traditional Medicare Hospice Program and that this provided a more sound business model. Effectively the waivers in the demonstration were ultimately not needed. One site never had any waivers. The other site became a traditional Medicare Hospice by becoming certified for and servicing patients in the community and not using the 20-inpatient cap. The demonstration learned much from the implementation of the quality measures, which was implemented using rapid response learning. Also, each site took on a project to increase awareness of and use of hospice services to underserved populations. The demonstration was designed to provide lessons learned for future planning of hospice quality measures since this demonstration was the first time Medicare required hospice providers to collect and report on quality measures. The quality measures were collected and reported using a secure web portal that provided the data in both tables and graphs such that trends could easily be viewed. The eight metrics were designed to cover hospice operations and to be:

- Patient-focused and outcome oriented;
- Valid, reliable, and feasible to use in hospice settings; and
- Meaningful to participating hospices.

These measures are:

1. Average pain severity on admission and after one day and two days of care for patients who: Report on admission that they are not satisfied with pain management; and/or Report (or have assessed) pain > 6 on admission (whether satisfied or not); and/or have a medication change for pain due to admission assessment.
2. Quarterly number of selected occurrences per 100 patient-days - aggregated for: All patients, Care centers, and Demo and Non-demo patients.
3. Quarterly LOS – % patients with LOS < 3 days and > 180 days
4. Percentage of patients for whom the time from admission to completion of the comprehensive assessment is < 5 days (Will also calculate frequencies for 1, 2, 3, 4, 5 and >5 days; and mean # days)
5. Percentage of "families" reporting "Always" on item D2 of the FEHC: how often the family was kept informed about the patient's condition
6. Quarterly turnover rates (FT/PT) include volunteers in core patient care positions
7. Quarterly vacancy rates; include volunteers in core patient care positions

8. Volunteer hours (patient care) To learn about issues in implementing aggregated quality measures, we used rapid response learning.

CMS' contractor provided technical support on how to implement these quality measures within their current business processes. The sites met via conference calls to discuss with the contractor and various CMS components issues with implementation, staff training, and other aspects of readying a hospice organization for collecting and reporting on aggregated quality measures. These calls resulted in identifying issues, such as the need to clarify some definitions or targeted staff training, and reconvening after revisions were made. Conference calls were also held between the sites and various CMS components after about each quarter or two of quality data was reported. This provided timely feedback to CMS and the sites about the process for data collection, team dissemination of information, analysis of the data, and usefulness of the data collection. These interactive calls with the feedback loop resulted ultimately in the sites' ability to report data consistently and accurately. CMS components received useful information for use in other hospice quality projects. A key to success in fostering the candid discussions that allowed the sites to share and act on their insights was trust and mutual respect between all parties. This strong relationship took time to develop. The sites reported that the aggregated metrics are a useful set of core measures, but that the occurrences should be based on 1000 patient days for easier analysis and review. This revision was included in CMS' future quality projects. The sites reported that the ability to access the measures online enabled each hospice to review its data by any of its staff and managers. This has improved awareness of the quality program and support at all levels of the hospices. The sites reported that the ability to view the measures graphically and tabularly has made it easier for them to understand, analyze, and discuss their data. Both sites identified opportunities for improvement and took action to improve performance. Verification and validation of the measures provided further insight that showed the importance for continued staff training for all aspects of quality reporting.

Description: Section 409 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) authorized a five-year demonstration for rural Medicare beneficiaries who are unable to receive hospice care at home for lack of an appropriate caregiver. These demonstration patients were provided such care in a rural facility of 20 or fewer beds that provides, within its walls, the full range of hospice services. The demonstration tested whether hospice services provided by a rural hospice that does not need to meet the cap on inpatient care days or provide hospice services outside of the facility results in wider access, improved hospice services, benefits to the rural community, and a sustainable pattern of care. The demonstration was awarded to the Sanctuary Hospice House (SHH) located in Tupelo, Mississippi and Haven Hospice (formerly Hospice of North Central Florida) headquartered in Gainesville, Florida. The demonstration also implemented a Quality Assessment and Performance Improvement (QAPI) Program following the CMS proposed Conditions of Participation (CoP's) for hospice with CMS receiving aggregated metrics electronically. QAPI means that the demonstration sites collect quality data, analyzes their data, and then develop performance improvement projects based on a review of its quality data. Metrics collections began July 2006 and in total 16 quarters of data were collected. The hospices report aggregated data using an electronic tool developed for the demonstration and in conjunction with the hospices using their work processes. The data are viewed in tables and graphs. This demonstration was the first time CMS collected quality data in the hospice industry. It resulted in the largest CMS database of aggregated quality measures since they were reported on all patients and the Average Daily Census (ADC) was at least 600 throughout the demonstration. Additionally the sites took on a project to increase awareness of hospice and use of hospice services to underserved populations. The demonstration started on October 1, 2005 and ended on September 30, 2010. ■

Sample Design and Data Analysis of the Medicare Health Plan CAHPS Surveys

Project No: HHSM-500-2005-00028I/0002
Project Officer: Elizabeth Goldstein
Period: September 2006 to September 2011
Funding: $13,242,343.00
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 contract was modified to increase the funding for Option Year 4 and to exercise Option Year 4. The total estimated cost plus fixed fee for full performance of this task order was increased from $10,246,633 to $13,242,343. The period of performance for this task order was extended to September 28, 2011.

Description: This task order implements sample design, data analysis, and reporting for the Medicare Consumer Assessments of Health Providers and Systems (CAHPS) Surveys among samples of persons in Medicare Advantage (MA) stand-alone Prescription Drug Plans (PDPs) and Medicare Fee-For-Service (FFS. In addition, to producing the scores for publicly reporting, the contractor creates plan-specific reports to help plans identify opportunities for improvement. ■

Save a Smile Program

Project No: 1C0CMS330729-01-00
Project Officer: Beth Benedict
Period: June 2010 to May 2011
Funding: $400,000.00
Principal Investigator: Samantha Twohig
Award: Grant
Awardee: Fond du Lac County
160 S. Macy Street
Fond du Lac, WI 54935

Status: The project is underway.

Description: This program will expand dental care access to Medicaid eligible children residing in Fond du Lac County, Wisconsin. It is is identifying eligible children and providers willing to participate in the Medicaid reimbursement program. It is assuring that preventive care is provided for children, and that necessary follow up appointments are made. The children are tracked for continued Medicaid eligibility and for follow through with dental care needs. ■

Second Phase of the HIFA Evaluation Study

Project No: HHSM-500-2005-00027I/0002
Project Officer: Barbara Dailey
Period: July 2006 to April 2010
Funding: $578,508.00
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 was fully funded, and was successfully completed on April 30, 2010 with all tasks complete.

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. ■

Sixty Plus Senior Care Transition - Piedmont Hospital

Project No: 1C0CMS030274/01
Project Officer: Pamela Pope
Period: July 2008 to June 2010
Funding: $191,593.00
Principal Investigator: Nancy Morrison
Award: Grant
Awardee: Piedmont Hospital
1968 Peachtree Road
Atlanta, GA 30309

Status: Piedmont Hospital has submitted notification of completing this 18 month demonstration project. The final narrative and financial status report have been received. This project was be scheduled for close out by OAGM.

Description: The program goal is to establish hospital and community partner interventions/processes to ensure safe and effective transitions for older adult patients and their caregivers, as they travel across the healthcare continuum and to home. The Transitions for Seniors Demonstration Project will design and implement an effective program to reduce hospital readmissions and unnecessary emergency room encounters, as well as improve the health care delivery system for older adults and their families by ensuring smooth transitions between healthcare settings and home. ■

Solicitation Management and Provisions of Remote Panel Reviews

Project No: HHSM-500-2006-00054G
Project Officer: Sona Stepp
Period: May 2006 to September 2010
Funding: $1,914,313.00
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. Additional grant solicitations were appropriated by Congress that resulted in an increase in the amount of the contract. The contactor is completing the contract tasks on time both effectively and efficiently. We are currently providing support to the Children's Health Insurance Program Reauthorization Act (CHIPRA) Grant Programs.

Description: The purpose of this task order is to provide complete grant application management and provision of remote grant panel reviews supporting grant programs. The contractor will manage the panel reviewer teleconferences for each panel and provide CMS with panel review results and documentation. ■

Steps of a Healthy Community

Project No: 1C0CMS030446/01
Project Officer: Diane Frankenfield
Period: August 2009 to January 2011
Funding: $ 95,000.00
Principal Investigator: Joan Procopio
Award: Grant
Awardee: University of Pittsburgh Medical Center
200 Lothrop Street
Pittsburgh, PA 15213

Status: The first and second Progress Reports and Financial Reports have been submitted. There have been numerous problems with this grant and work was suspended beginning in April 2010. The grant is being reviewed for continuation, deferment or termination.

Description: This program will focus on health disparities in the area of oral health. The University of Pittsburgh Medical Center (UPMC) Braddock is collaborating with the Allegheny Intermediate Unit (AIU) and Head Start to identify children without regular dental care with the objective of providing appropriate dental care to them, to seek to establish a dental home for every child and their family members, and to provide culturally competent oral health education to parents and children. UPMC is also collaborating with five Community Life (PACE) sites in the service area to provide annual checkups, teeth cleaning, extractions, dentures, and root canals while seeking to expand and increase access to preventive dental care and culturally competent oral health education. ■

Study to Assess the Impact of a Primary Care Practice Model Utilizing Clinical Pharmacist Practitioners (CPP) to Improve the Care of Medicare-Eligible Polulations in North Carolina, A

Project No: 1C0CMS030277/01
Project Officer: Maria Sotirelis
Period: July 2008 to December 2010
Funding: $ 95,305.00
Principal Investigator: Timothy Ives
Award: Grant
Awardee: University of North Carolina at Chapel Hill
School of Pharmacy, Box 7360
Chapel Hill, NC 27599

Status: Originally the grant period for the award ran from July 1, 2009 to December 31, 2009, and CMS granted a no cost extension which extended the grant period until December 31, 2010. In December 2010, CMS decided not to grant the awardee a second extension for six months because work for the study as originally proposed was not completed and a revised proposal submitted toward the end of the grant period was very different from what was originally proposed.

Description: The objective of this study was to examine the role of the clinical pharmacist practitioner (CPP) in managing drug treatment to reduce costs and improve the quality of care for Medicare beneficiaries. The methodology was a retrospective analysis of Medicare claims data for beneficiaries who did receive CPP services. The claims data for this population was to be compared to beneficiaries who did not receive CPP services. The study assessed the following parameters:

number of office visits, number of hospitalizations/ emergency room visits, and charges per visit. ■

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

Project No: HHSM-500-2006-00006I/0008
Project Officer: Steve Blackwell
Period: August 2007 to June 2011
Funding: $621,156.00
Principal Investigator: Grecia Marrufo
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 contractor is presently performing data analysis for the study. An interim report was provided in June, 2009. The base contract has been completed as of October, 2010. The website to the base contract report is as follows: http://www.cms.gov/Reports/Downloads/Acumen_PartBtoDBase_Final_2010.pdf For the option contract, data analysis is currently underway.

Description: This task order studies the issues involved with the relationship between Part B and Part D drug coverage. The Secretary's 2005 Report to Congress on Transitioning Medicare Part B Covered Drugs to Part D, 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. ■

Support for Senior Risk Reduction Demonstration (SRRD) and Cancer Prevention and Treatment Demonstration (CPTD)

Project No: HHSM-500-2005-00026I/HHSM-500-T0001
Project Officer: Diane Merriman
Period: September 2009 to September 2012
Funding: $372,997.00
Principal Investigator: Ron Goetzel
Audrey Weiss
Award: Task Order (MRAD)
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: The original five year contract ended September 29, 2009. A new three year contract was awarded September 15, 2009 to the same contractor to continue the support services for the Senior Risk Reduction Demonstration and Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities. The performance activities have continued seamlessly and without interruption.

Description: The purpose of this demonstration technical support contract is to provide support services to the Centers for Medicare and Medicaid Services (CMS) for the following two Medicare demonstrations: Senior Risk Reduction Demonstration (SRRD) and Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities. Activities include providing assistance to maintain the ongoing operation and integrity of these demonstrations through the analysis of project status/progress issues and solutions, preparation of project summary reports, project enrollment, recruitment and randomization tasks, data analysis, liaison with evaluation contractors, and conference coordination. ■

Support for the Medicare Care Management Performance Demonstration and Implementation Support for the Electronic Health Records Demonstration

Project No: HHSM-500-2006-00005I/0006
Project Officer: Debbie Vanhoven
Period: February 2008 to September 2015
Funding: $777,890.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The recruitment period for practices in the four Phase I sites (including Louisiana, Maryland, and the District of Columbia, 11 counties in S.W. Pennsylvania and South Dakota, and specific counties in bordering states) ended November 26, 2008. The demonstration began in these sites on June 1, 2009, and will continue through May 31, 2014. Plans to implement a second phase of the demonstration in eight additional locations were cancelled as a result of passage of the American Recovery and Reinvestment Act of 2009. However, Phase I is proceeding as originally planned. The contractor, Actuarial Research Corporation (ARC), was responsible for reviewing and tracking applications received from primary care practices in the Phase I sites; eligible practices were subsequently randomized into treatment and control groups. The contractor is providing a critical ongoing consultative role in the implementation and operation of the EHR demonstration including, but not limited to: aggregation of claims data, beneficiary assignment, and calculation of payment incentives under the demonstration.

Description: This task order supports the Centers for Medicare & Medicaid Services (CMS) in implementing and providing technical and administrative support in the operation of two pay for performance demonstrations: the Medicare Care Management Performance demonstration (MCMP) and the Electronic Health Records (EHR) demonstration. The implementation contractor shall be responsible for diverse tasks required for implementing and operating both demonstrations. ■

Sustaining Culture Change In Long Term Care

Project No: 1C0CMS030269/01
Project Officer: Michael Henesch
Period: July 2008 to May 2010
Funding: $ 95,305.00
Principal Investigator: Cheryl Cooper
Award: Demonstration
Awardee: Jefferson Area Board for Aging
674 Hillsdale Ave., Suite 9
Charlottesville, VA 22901

Status: The project ended on May 31, 2010.

Description: The objectives of this grant are focused on assisting one assisted living facility, the Mountainside Senior Living in Crozet, Virginia, and two nursing homes, the Laurels and Trinity Mission, both in Charlottesville, VA, in the culture change process. ■

System and Impact Research and Technical Assistance for CMS Fiscal Year 2005 Real Choice Systems Change Grants

Project No: 500-00-0049/0003
Project Officer: Claudia Brown
Period: September 2005 to September 2011
Funding: $4,797,835.00
Principal Investigator: Yvonne Abel
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The summaries of subsequent 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 are on time. Finalizations of the Strategic Plan web format and review and approval of ST Grantees Strategic Plans were 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 the 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 period in order to capture the activities and outcomes of the specific grants being evaluated under this task order. ■

Talking Fotonovelas to Improve Health Knowledge, Attitudes, and Practices Among Community Dwelling Older African Americans(Diabetes and High Blood Pressure)

Project No: 1IOCMS030310/02
Project Officer: Richard Bragg
Period: September 2008 to September 2011
Funding: $225,000.00
Principal Investigator: Elizabeth Bertera
Award: Grant
Awardee: Howard University OSP-Research Administration
2225 Georgia Avenue, NW 3rd Floor
Washington, DC 20059

Status: This grant has a no cost extension through September 29, 2011 under the Historically Black Colleges and Universities (HBCU) Health Services Research Grant Program

Description: Many older adults, who are racial or ethnic minorities, are most at risk for poor health outcomes. These individuals are also members of underserved populations comprised of individuals with low socioeconomic status and little education. Healthy People 2010 points to the gaps that exist among racial and ethnic groups in the rate of diabetes and associated complications in the United States. The specific objectives are to: 1) Develop a low-cost Talking Fotonovelas Program tailored to community-dwelling older African Americans residing in Washington, DC. 2) Field test the Talking Fotonovelas to improve diabetes and high blood pressure. 3) Examine associations among KAP and moderator variables in the Talking Fotonovelas conceptual model. Participants will be educated about behaviors conducive to prevention and self management of diabetes. In addition, prototypes of Talking Fotonovelas will be developed to use in health education with low socioeconomic status African Americans. ■

Technical Assistance for the Design and Implementation of a Home Health Pay-for-Performance Demonstration

Project No: HHSM-500-2005-00018I/0004
Project Officer: James Coan
Period: September 2006 to March 2011
Funding: $737,738.00
Principal Investigator: Henry Goldberg
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: CMS exercised Phase II of this contract to provide services for analysis of quality performance and savings calculations. The final report is due March 31, 2011.

Description: This task order will provide assistance to CMS in the design and implementation of a Home Health Pay-for-Performance Demonstration. Well qualified contractors will examine various pay-for-performance models and suggest an appropriate and feasible design for the Home Health Pay-for-Performance Demonstration. They will provide in-depth knowledge of the home health industry, OASIS, OBQI, OBQM, and pay-for-performance issues. In additional, the contractors will provide specific examples of recent projects on which they worked, which related to home health agencies, pay-for-performance, or both, and involved their having utilized CMS data systems and an in-depth understanding of the Medicare claims system. ■

TennCare II

Project No: 11-W-00151/04
Project Officer: Paul Boben
Period: May 2002 to June 2013
Funding: $ 0.00
Principal Investigator: Darin Gordon
Award: Waiver-Only Project
Awardee: Tennessee, Department of Finance and Administration, TennCare Bureau
301 Great Circle Road
Nashville, TN 37243

Status: Tennesse implemented the TennCare CHOICES managed long-term care program in middle Tennessee on March 1, 2010, and in the remainder of the State on August 1, 2010. The State received approval for Amendments #9 and #10 on June 30, 2010. Through these amendments, the State was authorized to make supplemental payments to private hospitals for their uncompensated cost of serving TennCare patients. The State share of these payments will come from permissible fees levied on the hospitals the fees, which in turn, allowed Tennessee to avoid significant TennCare benefit cuts. The State was also authorized to make a supplemental payment to the Regional Medical Center at Memphis, a public safety-net hospital, with the non-Federal share provided by Shelby County government. The amendment also made changes to rules governing cost sharing for children in TennCare Standard, among other reforms. On December 16, 2010, Amendment #11 was approved, to add Nashville General Hospital to the list of public hospitals eligible for a supplemental payment.

Description: TennCare II, implemented July 1, 2002, replaced 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. Medicaid State plan populations receive the TennCare Medicaid benefit package, while expansion populations receive TennCare Standard, with some State Plan benefits omitted. Individuals with demonstrated need for nursing facility level care can participate in the TennCare CHOICES, which provides integrated coverage for physical health, behavioral health, and long-term care services through a single managed care entity. CHOICES members who are able to remain in the community with assistance can request access to home and community-based services to help them stay in their homes. In 2005, TennCare coverage was discontinued for demonstration eligible uninsured adults, and the State plan non-pregnant medically needy adults group was closed to new enrollment. In November 2006, an amendment was approved to restore coverage to non-pregnant medically needy adults through the Standard Spend Down program, with enrollment capped at 105,000. The current list of expansion populations includes the Standard Spend Down group, children who qualify to receive TennCare Standard coverage after rolling over from Medicaid eligibility, and CHOICES members who qualify because they receive home and community-based services. ■

Texas Family Planning

Project No: 11-W-00233/06
Project Officer: Juliana Sharp
Period: December 2006 to December 2011
Funding: $ 0.00
Principal Investigator: Chris Taylor
Award: Waiver-Only Project
Awardee: Texas Health and Human Services Commission
1100 West 49th Street, Mail Code H100, P.O. Box 85200
Austin, TX 78708

Status: As of September 30, 2010, 111,358 individuals were enrolled in the Demonstration. The Demonstration is set to expire on December 31, 2011.

Description: This demonstration provides family planning services for uninsured women, aged 19 through 44, who are not otherwise eligible for Medicaid, SCHIP, Medicare or any other creditable health care coverage, and who have family income at or below 200% FPL. ■

Thurston County Project Access

Project No: 1C0CMS030276/01
Project Officer: Pamela Pope
Period: July 2008 to March 2010
Funding: $191,593.00
Principal Investigator: Susan Peterson
Award: Grant
Awardee: Thurston-Mason County Medical Society - VCI
1800 Cooper Point Road SW, #7-A
Olympia, WA 98502

Status: This project closed in March of 2010.

Description: Thurston County Project Access (TCPA) is a physician-led, community-based program that coordinates and provides donated medical care to low-income, uninsured adults who have an acute medical need and are currently uninsured. The objectives are to organize, acknowledge, and enhance provider volunteerism; to better leverage community resources; to decrease inappropriate use of the emergency room; and to stabilize their health safety net. The mission of Thurston County Project Access (TCPA) is to provide urgent medical care access to residents of Thurston County who are at, or below, 200% of the Federal Poverty Level, and are currently uninsured or underinsured. ■

Time Series Modeling and Related Economic Forecasting Methods in Long-Run Health Expenditure Projections

Project No: HHSM-500-2006-00006I/0015
Project Officer: Todd Caldis
Period: September 2008 to June 2010
Funding: $149,980.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contractor is working on a theoretical paper about time series methods as tools for projecting aggregate health expenditures in the long-run (75-years). The contractor is also working on an applied paper intended to make theoretical conclusions from the project accessible to a wider policy audience. The contract expired June 15, 2010. The papers are in final review.

Description: The purpose of this task order is to determine the immediate potential of time series methods and related economic forecasting methods as tools for improving long-range forecasts of health expenditures. Other goals of the task order are: 1) critically evaluating the existing research literature for forecasting aggregate health expenditures; 2) developing a research agenda in consultation with the Office of the Actuary concerning time series/economic forecasting of aggregate health expenditures; 3) completing forecasting studies to be agreed upon with the Office of the Actuary. ■

Time Study Project Data Collection and Analysis

Project No: 500-02-0030/0002 & HHSM-500-2008-00072C
Project Officer: Abigail Ryan
Jeanette Kranacs
Period: September 2005 to June 2012
Funding: $7,571,399.00
Principal Investigator: Jean Eby
Award: Task Order
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway
West Des Moines, IA 50266

Status: The project has marked the completion of the second phase of this multi-state nursing home staff time measurement study (also known as Staff Time and Resource Intensity Verification (STRIVE)). Following the collection of staff time and resident characteristic data on over 9,000 residents from 205 nursing homes across fifteen states and incorporating that information into a useable database, the second phase of the project's analysis formulated the RUG-IV case-mix groups and the RUG-IV methodology was finalized into rulemaking for implementation in October, 2010. Implementation of RUG-IV began by including the development of the RUG-34, 44 and 53 Medicaid Groupers. This contract also included analysis and pre-implementation efforts for Hybrid RUG-III. Post-implementation monitoring of RUG-IV began and the completion of the STRIVE Final Report continues.

Description: This contract was awarded to assure that payments to skilled nursing facilities (SNFs) remain accurate by reflecting current patient care practices, such as allocation of nursing home staff time to residents.

Medicare reimburses Part A skilled nursing services on a prospective payment system (PPS), which used the Resource Utilization Group, version three (RUG-III), case mix classification system to determine payments based on resident data. Introduced in 1998, the SNF PPS was constructed on the basis of staff time measurement studies conducted over a decade ago (in 1990, 1995, and 1997). Staff Time and Resource Intensity Verification (STRIVE) analysis suggested industry practices changed over the last decade, and CMS introduced RUG-IV through regulation to be effective October 2010. This will update SNF nursing rates, provide the means for states to update payment rates for their Medicaid nursing homes, and make available national data resulting from STRIVE analysis to State Medicaid agencies to evaluate their payment structures. The introduction of CMS's latest version of the assessment instrument, MDS 3.0, which STRIVE has analyzed to the extent its items collect resident characteristics necessary to case-mix classification under the RUG model, will be in October, 2010. This contract will continue to provide pre and post-implementation monitoring, evaluation and analysis of RUG-IV, provide technical support on RUG-IV specifications by responding to questions submitted by State agencies, and develop RUG-34, 44, and 53 Medicaid Groupers for RUG-IV. ■

Transparency and Public Reporting: Consumer Testing of Enhancements to CMS's Compare Tools

Project No: HHSM-500-2006-00009I/0008
Project Officer: David Miranda
Period: September 2008 to September 2011
Funding: $1,768,033.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is underway. The contract has been recently modified to exercise the option and the total estimated costs plus fixed fee was increased $716,004 from $1,052,029 to $1,768,033.

Description: This effort builds on earlier work of consumer testing language and displays of quality measures for plans and providers. It also builds on efforts to provide transparency regarding CMS payments, costs, and charges; consumer out-of-pocket costs; and various provider characteristics, such as volume of service. The content may focus on health or drug plans, or providers such as hospitals, nursing homes, dialysis facilities, home health agencies, medical groups, or physicians. ■

Uncompensated Care for Vulnerable Populations

Project No: 1C0CMS030443/01
Project Officer: Pamela Pope
Period: August 2009 to May 2011
Funding: $290,000.00
Principal Investigator: Lori Real
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: This project was processed as a supplement in June 2010 and extended until May 31, 2011. The progress and financial status reports were received on October 25, 2010 and the file is current.

Description: The purpose of this project is to distribute funds to supplement uncompensated care costs to increase access to care for vulnerable populations. Bi-State Primary Care Association is submitting an application for funds to supplement funding for uncompensated care for the vulnerable populations of seven Federally Qualified Health Centers and the Vermont Coalition of Clinics for the Uninsured, a free clinic coalition in Vermont. This grant application applies to Vermont only. The funding for this project will also address the health centers' provision of medical services to underserved patients beyond budgeted revenue. ■

Using Medicare/Medicaid Claims Data to Support Medication Outcomes and Pharmacovigilance Research

Project No: 1C0CMS330731-01-00
Project Officer: Pamela Pope
Period: June 2010 to May 2011
Funding: $500,000.00
Principal Investigator: Robin Buchannon
Benjamin Banahan
Award: Grant

Awardee: The University of Mississippi
135 Faser Hall, School of Pharmacy
Lafayette, MS 38677

Status: Grantee submitted abstracts and grant objectives for review and approval. The program office and OIS are currently reviewing.

Description: The goal of this project is to provide hands-on training experience in pharmacoepidemiology to graduate students so that they will be better able to meet the future manpower needs in this area. ■

Utah Primary Care Network

Project No: 11-W-00145/08 and 21-W-00054/08
Project Officer: Kelly Heilman
Period: February 2002 to June 2013
Funding: $ 0.00
Principal Investigator: Michael Hales
Award: Waiver-Only Project
Awardee: Utah, Department of Health (Box 141000)
P.O. Box 141000
Salt Lake City, UT 84114-1000

Status: On June 23, 2010, the Utah Primary Care Network Demonstration was extended for three years under provisions of section 1115(f) of the Act. The State has informed CMS of its continued interest to amend the Demonstration to provide premium assistance to low income individuals not otherwise Medicaid eligible for the purchase of private, non-group (aka individual) coverage.

Description: Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration that provides expanded access to Medicaid funded health care coverage, and additional options to provide premium assistance for employer-sponsored insurance (ESI) or COBRA continuation coverage. Through the demonstration, up to 25,000 uninsured adults age 19 and older with incomes up to 150% FPL may receive the PCN benefit, which includes coverage for a limited package of preventive and primary care services (i.e., no inpatient hospital coverage). Savings to fund the coverage expansion are generated by providing a reduced Medicaid benefits package and increased cost-sharing to certain able-bodied State plan eligibles who are categorically or medically needy parents or other caretaker relatives. Persons eligible for the PCN benefit with access to employer-sponsored health insurance (ESI) or COBRA continuation coverage may elect instead to receive premium assistance toward the purchase of that coverage. Children who are eligible for the State's CHIP program and who have access to ESI or COBRA also may elect premium assistance in lieu of CHIP coverage. Finally, high risk pregnant women, whose resources made them ineligible under the State plan, are covered under the Demonstration for the full Medicaid benefits package. ■

Vermont Global Commitment to Health

Project No: 11-W-00194/01
Project Officer: Robin Preston
Period: September 2005 to December 2013
Funding: $ 0.00
Principal Investigator: Susan Besio
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 December 23, 2010, a three year extension was approved for the Demonstration, starting January 1, 2011 through December 31, 2013. During the extension period, the State will receive Federal financial participation based on the actual cost of approved services and programs, rather than on the monthly per member-per month payments from DVHA to the Vermont Agency of Human Services, and will no longer be fully at risk for these services.

Description: Through the Vermont Global Commitment to Health Demonstration, the Department of Vermont Health Access (DVHA) operates as a public managed care entity. DVHA receives a monthly per member-per month (PMPM) 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 PMPM 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 an eight and a quarter-year aggregate budget neutrality expenditure limit of $8.9 billion. ■

Virginia Care Uninsured Program (VCUP)

Project No: 1C0CMS030440-01-01
Project Officer: Cindy Massuda
Period: August 2009 to May 2011
Funding: $490,000.00
Principal Investigator: Alan Richardson
Beth Darnley
Award: Grant
Awardee: Patient Advocate Foundation
700 Thimble Shoals Blvd., Suite 200
Newport News, VA 23606

Status: Hospice Foundation of America (HFA), http://www.hospicefoundation.org, is currently working on a CMS-funded project, the Hospice Outreach and Education Project, which seeks to raise awareness and knowledge of hospice care, including the Medicare and Medicaid hospice benefit. Aimed at the general population and also at groups that traditionally have low access rates to hospice care, as well as professionals who work in settings that may include end-of-life scenarios, the project provides collateral materials, webinars, and videos available on the Internet and on CD and DVD. Information on hospice and other aspects of end-of-life care and care giving is available through the project in English, Spanish and Chinese, the three most widely spoken languages in the U.S. The webinar portions of the project provide free continuing education to health and social service professionals. The materials, many of which are now available online at HFA's Hospice Information Center, will be distributed widely to hospice providers, healthcare providers and facilities, advocacy groups, libraries, associations and disease-specific organizations, as well as employee assistance programs. One additional aspect of the project includes Ask HFA, a phone and email resource that serves as a clearinghouse of information on hospice and end-of-life care. Qualified professionals, including a registered nurse, social worker, grief expert and program officer, provide information and support. Ask HFA receives emails and phone calls 24 hours a day, seven days a week (and responds within 24 hours, if not immediately to more pressing communications), from persons and professionals who ask questions or share their stories or concerns and have feedback provided by one of our experts experienced in hospice medical, emotional and spiritual care and support. Ask HFA receives an average of 70 communications each week. The website includes easy to access areas for consumers, including "Read and Share Resources" and "Educate Yourself and Others," which contain printable fact sheets on a wide range of topics related to hospice care, grief and bereavement, care giving and disease specific considerations when accessing end-of-life care. Some of these resources are available in Spanish and Chinese. The first of the webcast/video programs, "Understanding Hospice," was completed and posted on the Hospice Information Center portion of HFA's website at the end of summer. A Spanish-language version of that program was written, shot and produced separately, featuring a native Spanish-speaker and Spanish-language text in the graphics; it is in the process of being closed captioned. The next program was a first in end-of-life education: a Chinese-language video tutorial on hospice care aimed at the Chinese-American communities across the United States. It was debuted in November at a news conference in San Jose, CA, and received much attention both in local and national Chinese-language media; requests for the DVD program came to HFA almost immediately after the news conference. The program, "Understanding Grief," which features insights from Maria Shriver, current First Lady of California, is in the process of adding closed-captioning and will become available on the Hospice Information Center portion of HFAs website, as well as on DVD, by late December. A high definition public service announcement recorded at the same time is being distributed at no charge for use online (mostly hospice websites) and for use on broadcast television. The Spanish-language version of "Understanding Grief" was written, shot and is being produced as a separate program with Spanish language graphics and presented by a native-Spanish speaker; it will be completed by the end of the year. The program intended to inspire and motivate people to volunteer at their local hospice, "Time to Help Others," features several current hospice volunteers from around the country. It is expected to be available online and on DVD by year's end. Programs on how hospice is paid for (the Medicare Hospice Benefit), quality care, and serving under-served populations, are in various stages of production, and will be available early in 2011. HFA also has developed a series of easily accessible webinar programs that are useful to professionals and the public. Professionals can earn one hour of continuing education at no charge after viewing and taking a quiz on the webinar material. Certificates can be printed by the webinar attendee. Webinars now available through the Hospice Information Center include: Understanding Hospice, Understanding Grief, and Coping with Cancer at the End of Life, Family Caregiving and EOL Challenges in the LGBT Community. Five additional webinars will be completed by the end of January, including Hospice Care in Rural America, and Veterans and End-of-Life Care.

Description: Effective June 2010, the goal of this project is to continue to provide direct case management services at no cost to the uninsured and underinsured populations. The goal of this program is to continue to negotiate with the full continuum of social services, federal and state programs, and private sector resources

providing needed services in a timely, coordinated process to insure that no patient is without treatment or resources after a life altering diagnosis. The project will continue to provide sustained access to healthcare from initial contact with the patient through disease progression and the patient's treatment regimen. ■

Virginia Family Planning

Project No: 11-W-00152/03
Project Officer: Rebecca Burch Mack
Period: July 2002 to March 2011
Funding: $ 0.00
Principal Investigator: Gregg Pane
Award: Waiver-Only Project
Awardee: Virginia, Department of Medical Assistance Services
600 East Broad St, Suite 1300
Richmond,VA 23219

Status: On March 01, 2010, CMS approved an amendment to revise the list of approved procedure codes. On November 19, 2009, the State requested a three year extension of the Demonstration with a request to increase eligibility from 133 to 200% FPL, and several key changes to eligibility procedures. The renewal request is pending. The Demonstration is currently operating under a temporary extension set to expire on March 31, 2011. As of June 30, 2010, 5,378 individuals were enrolled in the Demonstration.

Description: This demonstration extends eligibility for family planning services to women who would lose Medicaid eligibility at the end of 60 days post-partum and to men and women of childbearing age with family income up to 133% FPL. ■

Virginia FAMIS MOMS and FAMIS Select

Project No: 21-W-00058/03
Project Officer: Ticia Jones
Period: June 2005 to June 2013
Funding: $ 0.00
Principal Investigator: Rebecca Mendoza
Award: Waiver-Only Project
Awardee: Maternal and Child Health Division, Department of Medical Assistance Services
600 East Broad Street, Suite 300
Richmond,VA 32319

Status: The State was awarded a three year extension on June 29, 2010.

Description: FAMIS MOMS provides full Medicaid coverage to pregnant women with incomes above 133% FPL up to and including 200% FPL. The demonstration also provides premium assistance for children eligible for Virginia's Children's Health Insurance Program (CHIP) who choose the FAMIS Select program. ■

Washington "Take Charge" Demonstration

Project No: 11-W-00134/00
Project Officer: Rebecca Burch Mack
Period: March 2001 to February 2011
Funding: $ 0.00
Principal Investigator: Doug Porter
Award: Waiver-Only Project
Awardee: Health and Recovery Services Administration
P.O. Box 45502
Olympia,WA 98504-5050

Status: On October 5, 2009, the State requested a three year extension, and is currently operating on a temporary extension set to expire February 28, 2011. The State is proposing to terminate the Demonstration on March 1, 2011 due to an across the board six percent budget cut related to state fiscal issues. The termination is pending legislative approval. As of December 31, 2009, 81,212 individuals were enrolled in the Demonstration.

Description: The purpose of the demonstration is to provide family planning services to uninsured men and women of childbearing age who are not otherwise eligible for Medicaid, SCHIP, or Medicare, and who have family income at or below 200% FPL. ■

Washington Transitional Bridge Demonstration

Project No: 11-W-00254/10
Project Officer: Kelly Heilman
Period: January 2011 to December 2013
Funding: $ 0.00
Principal Investigator: Doug Porter
Award: Waiver-Only Project
Awardee: Health and Recovery Services Administration
P.O. Box 45502
Olympia, WA 98504-5050

Status: The Washington Transitional Bridge Demonstration was approved on January 3, 2011. The project will extend through 2013.

Description: Washington's Transitional Bridge is a statewide section 1115 Demonstration to sustain coverage for early expansion-eligible individuals (Transition Eligibles) with countable household incomes up to and including 133 % FPL who are enrolled in the State-only Basic Health (BH), Disability Lifeline (DL), or Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs. Should these programs be eliminated, the enrolled individuals would lose their health care coverage until 2014 when they will become Medicaid-eligible due to passage of the Affordable Care Act. In addition to sustaining coverage, the Transitional Bridge Demonstration further serves the objectives of title XIX of the Social Security Act (the Act) by requiring Washington to seamlessly transition enrolled individuals to a coverage option available under the Affordable Care Act, and setting system modification milestones that will expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. ■

Waterbury Health Access Program (WHAP), The

Project No: 1C0CMS030275/01
Project Officer: Pamela Pope
Period: July 2008 to December 2009
Funding: $191,593.00
Principal Investigator: Roseanne Wright
Award: Grant
Awardee: City of Waterbury
65 Grand Street
Waterbury, CT 06706

Status: The project has been completed.

Description: The Waterbury Health Access Program (WHAP) is a multi-institutional collaborative of health organizations in Waterbury established with a Federal Health Resources and Services Administration grant in 2003 under the Healthy Communities Access Program. The collaborative, a continuation of a Community Action Grant coalition founded in 2000, was established to address systemic obstacles to ongoing and high-quality medical care for uninsured and underserved patients in the Greater Waterbury region. ■

Wisconsin BadgerCare

Project No: 11-W-00125/05 and 21-W-00001/05
Project Officer: Jessica Schubel
Period: January 1999 to December 2013
Funding: $ 0.00
Principal Investigator: Dennis Smith
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: On December 30, 2010, CMS approved a three year extension of this Demonstration, for the period beginning January 1, 2011 through December 31, 2013. As of January 1, 2010, waiver authorities no longer apply to Medicaid-eligible children with incomes of 100-200% FPL, or parents with incomes up to 130% FPL. The expenditure authority allowing the State to provide CHIP coverage to parents with income between 130 and 200% FPL was rescinded. Instead, the renewed Demonstration will allow the State to postpone Medicaid eligibility for parents and caretaker relatives with incomes between 150 and 200% FPL who have or recently had access to employer-sponsored insurance, and to not provide three months of retroactive eligibility, using existing waiver authorities.

Description: The BadgerCare Demonstration provides the State waiver authorities which allow it to postpone Medicaid eligibility for parents and caretaker relatives with incomes between 150 and 200% FPL who have or recently had access to employer-sponsored insurance, and not to provide them three months of retroactive eligibility. The purpose of these restrictions is to limit the possibility that offering Medicaid eligibility will

crowd-out private health insurance. The BadgerCare Demonstration in its original form was designed as a health insurance program to provide 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 sought to provide a safeguard against increasing the number of uninsured families and children as a result of Wisconsin's welfare reform program. Over the years, many of the key features of BadgerCare were incorporated into Wisconsin's Medicaid and CHIP State plans, taking advantage of new State plan options that were not available at the time BadgerCare was first approved. The current Demonstration provides a limited set of waivers needed to continue the features of the original BadgerCare Demonstration that cannot be accommodated in a State plan. ■

Wisconsin BadgerCare Plus Health Insurance for Childless Adults

Project No: 11-W-00242/05
Project Officer: Jessica Schubel
Period: December 2008 to December 2013
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: Wisconsin, Department of Health and Social Services
P.O. Box 7935
Madison, WI 53707-7935

Status: Two pending amendment requests are being reviewed at this time. The State would like to impose an aggregate cap on physical and mental health visits and is requesting to increase cost-sharing requirements on the Demonstration population.

Description: The BadgerCare Plus expansion to low-income childless adults is the second step in a comprehensive strategy to ensure access to affordable health insurance for virtually all Wisconsin residents. The demonstration population consists of adults without dependent children, between the ages of 19 and 64 and with incomes that do not exceed 200 % FPL. The program includes new and innovative features including, 1) centralized eligibility and enrollment functions, 2) requirement for participants to complete a health needs assessment that will be used to match enrollees with health maintenance organizations (HMOs) and providers that meet the individual's specific health care needs, 3) the tiering of health plans based on quality of care indicators, and 4) enhanced online and telephone application tools that will empower childless adults to choose from a variety of health insurance options. ■

Wisconsin Family Planning

Project No: 11-W-00144/05
Project Officer: Juliana Sharp
Period: June 2002 to January 2011
Funding: $ 0.00
Principal Investigator: Dennis Smith
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: On April 8, 2010, CMS approved an amendment to the Demonstration to extend coverage to males, remove the creditable coverage requirement to allow individuals with insurance coverage for family planning services to enroll in the Demonstration and follow standard Medicaid rules regarding third party liability, and cover follow-up procedures at FMAP. As of March 31, 2010, 68,113 individuals were enrolled in the Demonstration. On June 29, 2010, the State also submitted a Medicaid State plan amendment (SPA) to pursue the State plan family planning eligibility option. The Demonstration was set to expire on December 31, 2010, but was granted a temporary extension through January 31, 2011 to provide more time to finalize the SPA.

Description: This demonstration provides family planning services to women between the ages of 15 and 44, with income at or below 185% FPL, who are not otherwise Medicaid eligible. ■

Wyoming 'Pregnant By Choice' Demonstration

Project No: 11-W-00238/08
Project Officer: Rebecca Burch Mack
Period: September 2008 to August 2013
Funding: $ 0.00
Principal Investigator: Teri Green
Award: Waiver-Only Project

Awardee: Wyoming, Department of Health
6101 N. Yellowstone Road, Room 259B
Cheyenne, WY 82002

Status: As of June 30, 2010, 571 individuals were enrolled in the Demonstration.

Description: The Wyoming "Pregnant By Choice" Demonstration provides coverage for family planning services to all uninsured women age 19-44 with family incomes at or below 133% FPL who are not otherwise eligible for Medicaid, SCHIP, or Medicare ■

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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