2010 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 identifi cation number, the project title, the project number, the CMS project officer, the awardee,funding, principal investigator, and the period of performance. More detailed information regarding specific projects may be obtained directly from CMS project officers. This is the twenty-eighth 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-TO002
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 in its first year of the three year project time frame. Payments have been distributed to beneficiaries on a monthly basis, as required.

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 demonstration for both cardiovascular and orthopedic procedures on May 1, 2009.

Description: This 3-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 3-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: Data analysis for this contract is continuing and draft reports to CMS of findings for the two component cohorts, nursing home residents and community dwellers, will be submitted. A seminar will be held at CMS in 2010 to present preminary findings and elicit CMS expertise toward the final analysis plan. The Final two-part report to CMS is due in September 2010.

Description: This task order will conduct analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. This task order was extended an additional year April of 2008, and has now been extended one final year, until 9/30/2010. ■

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: The period of performance has been extended through January 31, 2010.

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

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 December 15, 2009, Alabama requested to amend the demonstration to add the procedure code for Implanton to the list of approved procedure codes. The amendment request is under review. As of December 31, 2009, 75,442 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% Federal Poverty Level (FPL). ■

Alaska Denali KidCare

Project No: 11-W-00186/10
Project Officer: Jeffrey Silverman
Period: September 2004 to September 2009
Funding: $ 0.00
Principal Investigator: Barbara Hale
Award: Waiver-Only Project
Awardee: Medicaid and Health Care Policy
P.O. Box 110660
Juneau, AK 99811-0660

Status: This demonstration ended in September 2009.

Description: The Denali KidCare demonstration provides Alaska the authority to maintain a 12-month period of uninsurance for applicants whose income exceeds 150% but does not exceed 175%, of the 2003 Federal Poverty Level (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: Project work is underway. The contractor is in the process of conducting analyses of episode-based and per capita approaches. An interim report summarizing work to date is in progress.

Description: CMS and others in the policy community have been increasingly interested in moving to a value based purchasing (VBP) system for physicians under traditional 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 serviceswould receive larger payment updates than physicians providing similar or lower quality services with more resources. CMS and other groups have focused on the use of commercially developed episode groupers to measure resource use, but there exists little peer reviewed literature that evaluates these groupers, and few studies have examined feasible alternatives in Medicare. The purpose of this task order is to suggest and develop alternative approaches to the commercial episode grouper-based physician resource use measures. ■

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

Project No: 500-00-0031/0003
Project Officer: Karyn Anderson
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. Phase II is in process.

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. ■

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: $351,999.00
Principal Investigator: Michael Myer
Award: GSA Order
Awardee: Kauffman and Associates, Inc.
South 165 Howard Suite 200
Spokane, WA 99201

Status: The project is underway.

Description: The purpose of this task order is 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 2010
Funding: $2,301,991.00
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, and three have been exercised.

Description: This contract, with an option to extend the period of performance beyond fiscal year 2010 for a fourth option year, (i.e. through the fiscal year ending September 24, 2011), allows the Kidney Epidemiology and Cost Center (KECC), through the Regents of the University of Michigan, to conduct end stage renal disease (ESRD) prospective payment system (PPS) research. The project involves the analysis of administrative data, case mix information, and the development of methods to establish and implement a case-mix adjusted PPS for outpatient ESRD facilities. This research will also build on, extend, and update previously completed phased research efforts to develop a fully bundled ESRD PPS, one that expands the routine maintenance dialysis services currently reimbursed under the composite payment system to include separately billable services. The development and implementation of a fully bundled ESRD PPS beginning January 1, 2011, along with other adjustments specified by statute, is required in accordance with section 153(b) of Public Law 110-275, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). 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 March 2011
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. ■

Arizona Health Care Cost Containment System

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

Status: Effective July 1, 2009, Arizona exercised its option to claim title XXI matching funds for nonpregnant childless adults (the Health Insurance Flexibility and Accountability (HIFA) Waiver I population). Prior to this, Arizona had received matching funds for this population at the title XIX rate. On October 1, 2009, Arizona returned to claiming title XIX matching funds for HIFA I, and completely ended CHIP coverage for parents (HIFA II population). On October 1, 2009, Arizona submitted a request to amend the demonstration to implement a Community Transition Services benefit to the long-term care component of the demonstration Arizona Long Term Care System (ALTCS), to assist members living in institutions (nursing facility or Intermediate Care Facilities for the Mentally Retarded (ICF/MR)) who wish to return to community living in a home or apartment.

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% Federal Poverty Level (FPL) who are otherwise ineligible for Medicaid at the end of 60 days post-partum. This demonstration permits Arizona 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: Thomas Hennessy
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: On July 28, 2009, Arkansas's request for a three-year extension for the demonstration was approved. As of December 31, 2009, 60,555 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, CHIP, Medicare, or Arkansas's Health Insurance Flexibility and Accountability (HIFA) Waiver demonstration, who have no other creditable coverage; and whose family income is at or below 200% Federal Poverty Level (FPL). ■

Arkansas Safety Net Benefit Program

Project No: 21-W-0051/06 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 December 31, 2009, 415,768 individuals were enrolled in this demonstration.

Description: Arkansas's Health Insurance Flexibility and Accountability (HIFA) Waiver 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% Federal Poverty Level (FPL). ConnectCare, Arkansas's Primary Care Case Management (PCCM) program formerly operated under 1915(b) authority, also has been subsumed into this demonstration. ConnectCare is mandatory for Temporary Assistance to Needy Families (TANF), TANF-related, Supplemental Security Income (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 Arkansas'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 2010
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, 2009, 3,215 individuals were enrolled in this demonstration.

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 (TEFRA). A sliding scale premium is assessed to families based on income. Services are delivered through Arkansas'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: Ticia Jones
Period: August 1997 to March 2010
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: In 2009, the demonstration operated under a series of temporary extensions, and is currently on temporary extension, pending consideration of Arkansas's request for a three-year extension through September 30, 2012. As of December 31, 2009, 101,312 children were enrolled in this demonstration.

Description: The ARKids B demonstration provides coverage for CHIP children through age 18 with family income above the Medicaid income level and up to and including 200% Federal Poverty Level (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 1 to 4 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
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The TEP will have its first meeting in February, 2010. Efforts to support the contract are underway.

Description: This project will measure ASD activity in 50 states, and collect 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. will provide advice to the contractor and CMS as the project progresses. ■

Basic Medicaid for Able-Bodied Adults

Project No: 11-W-00181/08
Project Officer: Kelly Heilman
Period: January 2004 to April 2010
Funding: $ 0.00
Principal Investigator: Duane Preshinger
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 July 29, 2009, Montana submitted a revised proposal to extend and significantly amend the demonstration. The revised proposal is under review. Since February 2009, the demonstration has operated under a series of temporary extensions, to allow time for negotiations over a longer term extension. Currently, the demonstration has a temporary extension through April 30, 2010.

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

Bedford Ride Program

Project No: 1C0CMS030271/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $ 95,000.00
Principal Investigator: Brenda Lipscomb
Award: Grant
Awardee: Central Virgina Area Agency on Aging, Inc.
3024 Forest Hills Circle
Lynchburg,VA 24501

Status: The project is underway.

Description: This program will provide non-emergency medical transportation for all Bedford City and County citizens, except for those who are Medicaid Transport eligible. This transportation includes trips to and from dialysis treatments, cancer treatments, and for preventive medical diagnosis. These trips will be provided to those who have no other means of transportation. ■

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: The first period of performance (POP) for this project was from 7/27/2008 to 12/31/2009, with an award amount of $66,812. The continuation extended the POP to 12/31/2010, 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. ■

Beneficiary Selection in the Medicare Prescription Drug Program

Project No: CMS-ORDI-2008-0003
Project Officer: Gerald Riley
Period: December 2006 to January 2009
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The results of this study have been published in the Health Affairs journal. See: "Riley GF, Levy J, Montgomery M. Beneficiary selection in the Medicare prescription drug program. Health Affairs. Vol. 28, No. 6, pp. 1826-1837. November/December 2009."

Description: Medicare Current Beneficiary Survey and Part D enrollment records are being used to examine selection patterns into various drug coverage arrangements in 2006. ■

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

Project No: 500-00-0033/0010
Project Officer: Noemi Rudolph
Period: September 2005 to June 2009
Funding: $1,530,214.00
Principal Investigator: Leslie Foster
Mary Laschober
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The First Annual Report was submitted to CMS and the findings were discussed from a state survey and the first round of stakeholder interviews and focus groups. Case study site visits were also completed and a case study report has been submitted to CMS. The final report has been completed and can be found at: http://www.cms.hhs.gov/reports/downloads/Laschober_2009.pdf.

The Report to Congress has been completed and can be found at: http://www.cms.hhs.gov/reports/downloads/Leavitt_RTC_Best_Practices_Enrolling_LI.pdf.

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

California Family Planning, Access, Care, and Treatment Program

Project No: 11-W-00143/09
Project Officer: Thomas Hennessy
Period: December 1999 to June 2010
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 in November of 2004 and had been operating under a series of short-term extensions until there was an approval of a full three-year extension. Approximately 1.65 million individuals received family planning services through the demonstration.

Description: This demonstration expands Medicaid coverage for family planning services to men and women of childbearing age with incomes up to 200% Federal Poverty Level (FPL). ■

California Medi-Cal Hospital Uninsured Care

Project No: 11-W-00193/09
Project Officer: Steven Rubio
Period: August 2005 to August 2010
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 January 27, 2010, a package of amendments was approved by CMS. These include clarification of the annual limits on Safety Net Care Pool (SNCP) expenditures to allow California to benefit from the increased federal matching rate under the American Recovery and Reinvestment Act of 2009, approval of up to $720 million (total computable) in additional SNCP expenditures for existing state-funded health care programs and SNCP-eligible costs in demonstration Year 5, and removal of the prohibition on new provider taxes.

Description: This demonstration restructures the financing of California's share of Medicaid expenditures for governmental hospitals, creates a Safety Net Care Pool ($1,532 million per year, total computable) to fund provider claims for care for the uninsured, and continues the authority of California to selectively contract with hospitals for negotiated rates. Of the Safety Net Care Pool, $360 million per year (total computable) is available contingent on California meeting milestones related to expansion of Medicaid managed care for Aged, Blind, and Disabled (ABD) populations (demonstration Years 1 and 2) and implementation of a Coverage Initiative (CI) for the uninsured (demonstration Years 3 through 5). California did not meet the requirements spelled out for Years 1 and 2. The following are the guiding principles that were used to provide the framework for the Coverage Initiative (CI):

- use of organized delivery systems to manage the care of the uninsured; · promotion of the use of preventive services and early intervention; · promotion of personal responsibility for service utilization;
- the CI is not an entitlement program for the state, beneficiaries, or participating providers;

- cover uninsured individuals who have no eligibility for Medi-Cal or Healthy Families; and
- develop the CI in a manner to ensure long term viability within existing safety net health care systems.

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

Cancer Diagnosis and Treatment Among Medicare Managed Care Enrollees

Project No: ORDI-06-100106
Project Officer: Gerald Riley
Period: October 2006 to October 2008
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 was published in "Medical Care" in October of 2008. The project is now complete.

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

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities

Project No: 1A0CMS300066/01
Project Officer: Diana Ayres
Period: September 2006 to September 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 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 is due September 2010. The four year demonstration, which started September 2006, is scheduled to end September 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 September 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 is due September 2010. The four year demonstration, which started September 2006, is scheduled to end September 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: 1A0CMS300068/01
Project Officer: Diane Merriman
Period: September 2006 to September 2010
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. 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 next Report to Congress is due September 2010. The 4-year demonstration, which started September 2006, is scheduled to end September 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 6 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 September 2010
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 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 is due September 2010. The four year demonstration, which started September 2006, is scheduled to end September 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: 1A0CMS200070/01
Project Officer: Kathleen Connors de laguna
Period: September 2006 to September 2010
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: 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 is due September 2010. The four year demonstration, which started September 2006, is scheduled to end September 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: 1A0CMS300065/01
Project Officer: Kathleen Connors de laguna
Period: September 2006 to September 2010
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: 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 next Report to Congress is due September 2010. The 4-year demonstration, which started September 2006, is scheduled to end September 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 6 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: $ 29,400.00
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: A draft manuscript is expected to be submitted in early 2010 for possible publication.

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. ■

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.

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
Barbara Gage
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The contract has been awarded and is in it's early development phase.

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 Logic of Episode Groupers

Project No: HHSM-500-2006-00008I/0002
Project Officer: Fred Thomas
Period: August 2007 to June 2009
Funding: $499,503.00
Principal Investigator: David Kennell
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: A Report entitled, "Clinician feedback on using episode groupers with Medicare claims data (2010)" is complete and available on the web (under research).

Description: CMS contracted with Kennell and Associates to explore episode grouping issues from the clinician's perspective. In 2008 eight clinician panels at four practice sites were given a presentation on grouping and asked to comment on grouping issues. ■

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: $199,937.00
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. 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 September 2011
Funding: $149,993.00
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 project is underway. The demonstration will end 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 will continue through 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 contract expired on 9/30/2009. ■

Colorado Adult Prenatal Coverage and Premium Assistance in CHP+

Project No: 21-W-00014/08
Project Officer: June Milby
Period: September 2002 to March 2010
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 but has been continued through temporary extensions as terms for a longer extension are discussed. As of December 31, 2009, 3730 women and 102,395 children were enrolled in this demonstration.

Description: This demonstration expands coverage under CHIP to pregnant women with incomes above 133% Federal Poverty Level (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. ■

Comparison of Cancer Diagnosis and Treatment in Medicare Fee-for-Service and Managed Care Plans

Project No: CMS-ORDI-2008-0001
Project Officer: Gerald Riley
Period: October 2006 to October 2008
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 published in the October 2008 issue of Medical Care. Citation: "Riley G.F., Warren J.L., Potosky, A.L., Klabunde, C.N., Harlan, L.C., and Osswald, M.B. Comparison of Cancer Diagnosis and Treatment in Medicare Fee-for-Service and Managed Care Plans. Medical Care, vol. 46, issue 10, pp. 1108-1115, October 2008."

Description: SEER-Medicare data were used to compare stage at diagnosis and treatment patterns for cancer among elderly Medicare beneficiaries in the managed care and fee-for-service sectors. ■

Consumer-Directed Chronic Outpatient Services Demonstration

Project No: ORDI-05-0007
Project Officer: Claudia Lamm
Pauline Lapin
Period: January 2005 to January 2009
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: CMS and its co-sponsoring organization, ASPE, started conducting ongoing meetings with the demonstration design contractors, Medstat and Abt Associates. The contractors delivered a best practices report and a technical advisory group (TAG) had been identified and met early on in the contract. The TAG made recommendations to our contractors on the demonstration's target population and site selection. Internal meetings were held to discuss demonstration design options. A Technical Advisory Group, convened to consider the demonstration design,was skeptical about its feasibility. CMS and its partner in the demonstration, ASPE, approached potential sites with the infrastructure needed to implement the proposed model; there was only one potential participant. However, they offered a potential pool of only 40 Medicare beneficiaries who would meet the demonstration criteria. Therefore, CMS and ASPE concluded that it was not feasible to implement the demonstration.

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

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, has implemented a rural case management program targeting beneficiaries in northern Iowa with various chronic conditions. The site is currently enrolling beneficiaries and providing coordinated care services. 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 March 2010
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 was extended twice for a total of four additional years in order to further test the cost effectiveness of Health Quality Partners' coordinated care interventions.

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. ■

Data Collection for the Second Generation S/HMO Demonstration

Project No: 500-01-0025/0003
Project Officer: Dennis Nugent
Period: September 2004 to October 2008
Funding: $3,224,421.00
Principal Investigator: Todd Ensor
Award: Task Order (ADDSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The S/HMO-II demonstration data collection contract with Mathematica ended on October 29, 2008.

Description: The Social Health Maintenance Organization (S/HMO) Demonstration began in 1985. It was conducted in response to section 2355 of Public Law 98-369 (the Deficit Reduction Act of 1984), which authorized the Secretary of DHHS to approve applications and protocols submitted to waive certain requirements of title XVIII and title XIX of the Social Security Act to demonstrate the concept of a social HMO. This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration, which was implemented in 1996. The work was done by Mathematica Policy Research under a subcontract until Fall 2004, at which time a contract was awarded to Mathematica to continue the data collection work. Originally, initial and annual follow-up surveys were administered to each beneficiary enrolled in the S/HMO-II demonstration. Subsequently, a sampling method was utilized. The information gathered served three primary functions: baseline and follow-up data for the analyses, clinical information to the participating S/HMO-II site for care planning, and data for risk-adjustment and payment ■

Delaware Diamond State Health Plan

Project No: 11-W-00036/03
Project Officer: Joseph Gaiser
Period: May 1995 to June 2010
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: Delaware submitted a request for a 3-year extension on July 1, 2009. The demonstration is currently operating under a temporary extension through June 30, 2010.

Description: The Diamond State Health Plan (DSHP) demonstration implements mandatory Medicaid managed care, and uses savings to cover additional parents and uninsured adults with incomes up to 100% of the Federal Poverty Level (FPL). Delaware 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: Juliana Tiongson
Period: January 2001 to December 2011
Funding: $ 0.00
Principal Investigator: Kristine Ragaglia
Award: Waiver-Only Project
Awardee: Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Status: Connecticut has accepted settlements for Fiscal Years 2001-2007.

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: Juliana Tiongson
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.

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 Ssate believes may have a potential to also be covered by Medicare. ■

Demonstration to Maintain Independence and Employment - District of Columbia

Project No: 11-P-91421/03
Project Officer: Claudia Brown
Stephen Hrybyk
Period: January 2002 to December 2008
Funding: $20,713,679.00
Principal Investigator: Robert Cosby, M.D.
Award: Grant
Awardee: District of Columbia, Department of Health, Medical Assistance Administration
Suite 5135, N. Capitol St., NE
Washington, DC 20002

Status: The DMIE program for the District of Columbia has ended. More than half of the study participants receiving services through the demonstration continue to receive care through other appropriate programs offered in the District of Columbia.

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

average of $8,635 per enrollee. Eighty-three percent of the expenditures have been for prescription drugs. ■

Demonstration to Maintain Independence and Employment - Kansas

Project No: 11-P-92389/07-01
Project Officer: Claudia Brown
Period: April 2006 to September 2009
Funding: $20,886,739.00
Principal Investigator: Mary Ellen O'Brien Wright
Award: Grant
Awardee: Kansas, Department of Social and Rehabilitation Services
915 Harrison St. 6th Floor North
Topeka, KS 66612-1570

Status: Provision of services covered by the Demonstration program ended in 2009. The State continues to evaluate data to produce evaluation findings. The official ending of the evaluation is slated for December 2010.

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). This demonstration will provide state Medicaid and other health and employment support services as wraparound coverage to a targeted 200 people with health insurance through the Kansas high-risk pool, also known as the Kansas Health Insurance Association (KHIA). People in the high-risk pool experience multiple severe conditions for which they have been unable to obtain employer-sponsored coverage or reasonably priced private coverage. They are ineligible for either Medicaid or Medicare and about one-third of participants are employed. The goals of the project are to improve the health and quality of life of individuals in the intervention group and to demonstrate that, compared to a carefully matched control group of 200 individuals also in the pool, they maintain a higher rate of employment and are less likely to become eligible for any form of Social Security disability benefits or other forms of public assistance. ■

Demonstration to Maintain Independence and Employment - Minnesota

Project No: 11-P-92387/05-01
Project Officer: Claudia Brown
Period: November 2006 to September 2009
Funding: $54,246,962.00
Principal Investigator: MaryAlice Mowry
Award: Grant
Awardee: Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: This Demonstration program officialy stopped providing services to study participants at end of 2009. The State is continuing to evaluate study data to produce a comprehensive State level evaluation report.

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

Demonstration to Maintain Independence and Employment - 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. ■

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

Project No: HHSM-500-2005-00024I/HHSM-TO002
Project Officer: Linda Lebovic
Period: April 2009 to April 2010
Funding: $748,184.00
Principal Investigator: Charlie Bruetman
Award: Task Order (MRAD)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Status: The publication of the solicitation is anticipated for early 2010. A panel will review the proposals and make recommendations for selection. 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 throgh 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. ■

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: $1,379,360.00
Principal Investigator: David Kennell
Kathleen Dalton
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project kickoff meeting was held on July 18, 2008. The Report to Congress was submitted to CMS in February, 2009. The research design for additional studies was due in late 2009. The patient margins analysis has begun, and site visits and other additional studies will begin during early 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 2 and 3. 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: David Bott
Period: January 2008 to January 2013
Funding: $2,923,940.00
Principal Investigator: Ed Drozd
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 was completed and made available to the public (http://optherapy.rti.org/). The DOTPA Project Annual Report was 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 5-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 February 2010
Funding: $473,961.00
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.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=ascending&itemID=CMS023785.

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

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: Barbara Sterry
Jose Calderon
Award: Grant
Awardee: Nova Southeastern University, College of Pharmacy
3301 College Avenue
Fort Lauderdale, FL 33314

Status: The grant is in its second year (continuation) under the Hispanic Health Services Research Grant Program.

Description: Type 2 diabetes is a national epidemic affecting an estimated 21 million individuals. The prevalence of diabetes among the Latina 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-efficiacy (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. ■

District of Columbia Childless Adults Aged 50-64

Project No: 11-W-00139/03
Project Officer: Camille Dobson
Period: March 2002 to September 2011
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 District of Columbia submitted an amendment request on November 27, 2009, to use an additional $28 million in DSH funds to expand coverage to District residents age 21–31 with incomes at or below 200% Federal Poverty Level (FPL). This request is under consideration.

Description: This demonstration extends coverage to childless adults age 50-64 with incomes up to 50% FPL. These adults receive full Medicaid benefits delivered through managed care organizations. The demonstration is funded by diverted Disproportionate Share Hospital (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: Camille Dobson
Period: January 2001 to June 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 scheduled to expire on January 13, 2010; however, that expiration date has been temporarily extended until June 30, 2010. CMS will require a new extension application to be submitted by April 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 of Columbia purchasing HIV/AIDS drugs from the Department of Defense, rather than through the regular Medicaid program. ■

Efforts to Enhance Availability and Quality of Managed Long Term Care

Project No: HHSM-500-2006-00009I/HHSM-500-T0001
Project Officer: Mary Sowers
Period: August 2009 to August 2010
Funding: $223,407.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is underway.

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. ■

Emergency funds to 13 of New Hampshire's community health centers to address the provision of medical services to indigent patients.

Project No: 1C0CMS030267/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $618,000.00
Principal Investigator: Lori Real
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: The project is underway.

Description: This program will provide emergency funding to 13 non-profit community based providers of comprehensive, primary, and preventive health care services. These 13 sites provide services regardless of a patient's ability to pay and they operate in geographic areas designated as medically underserved by the federal government. The objective of this grant is to provide emergency funding for the uncompensated care that New Hampshire health centers provide to patients who lack insurance or are underinsured. ■

End Stage Renal Disease (ESRD) Measures Support Work

Project No: HHSM-500-2005-00031I/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 has been modified to revise the Period of Performance ending date from 06/30/2009 to 3/31/2010.

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: United Healthcare Insurance Co. (Evercare)

Project No: 95-W-00186/05
Project Officer: Maria Sotirelis
Period: January 2006 to December 2008
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: United Healthcare Insurance Company
9701 Data Park Drive
Minnetonka, MN 55343

Status: In September 2008, CMS and United Healthcare Insurance Company agreed to a mutual termination of their Medicare Advantage contract for both Evercare of Arizona and Evercare of Georgia effective midnight December 31, 2008. The termination of the contract will end the plans' participation in the demonstration.

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. Ordinarily, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage plans. This demonstration has made an exception to the rule, allowing MA organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis/MA organization was required to provide all Medicare covered benefits. Organizations serving ESRD patients received the same risk-adjusted ESRD capitation payments as for the MA program overall, with separate rates for dialysis, transplant, and post-transplant modalities. United Healthcare Insurance had two ESRD only MA special needs plans operating under this demonstration. These plans were Evercare of Georgia and Evercare of Arizona. The first plan, Evercare of Georgia, started enrolling in February 2006. Evercare of Arizona began enrollment in January 2007. The actual payment amount was reduced by 5 percent and will be made available depending on performance on quality measures. CMS has determined six dialysis-related indicators on which performance will be assessed. The indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, Arbor Research. ■

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

Project No: 95-W-00188/09
Project Officer: Siddhartha Mazumdar
Period: January 2006 to December 2010
Funding: $ 0.00
Principal Investigator: Allison Kato
Award: Waiver-Only Project
Awardee: DaVita, Inc.
601 Hawaii Street
EL Segundo, CA 90245

Status: The Medicare Advantage organization began enrolling patients on January 1, 2006. The enrollment as of January 2010 was 437. The demonstration has been extended for one more year, until December 31, 2010.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. This demonstration allows 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 will receive the same risk-adjusted ESRD capitation payments as for the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities. The actual payment amount, however, will be reduced by five percent, which will be available to the organizations depending on their performance on quality measures. CMS has determined six dialysis-related indicators on which performance will be assessed. These indicators are: adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, Arbor Research Collaborative for Health. ■

End-stage Renal Disease (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 began enrolling patients January 1, 2006. The total enrollment in all FMCHP plans as of January 2010 is 726 beneficiaries. In 2010, FMCHP plans are available to beneficiaries with ESRD in select counties in the following States: Alabama, California, Connecticut, Illinois, Massachusetts, Minnesota, New York, Pennsylvania, Rhode Island, Tennessee, and Texas.

Description: The End-stage Renal Disease (ESRD) Disease Management Demonstration increases the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. In this demonstration, dialysis companies have partnered with Medicare Advantage (MA) organizations to offer MA plans in specified service areas that enroll only beneficiaries with ESRD. The dialysis/MA organization must provide all Medicare covered benefits. Organizations serving ESRD patients will receive the same risk-adjusted ESRD capitation payments as the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities. The actual payment amount, however, will be reduced by 5 percent, which will be available to the organizations depending on performance on quality measures. CMS has determined six dialysis-related indicators on which performance will be assessed. These indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, Arbor Research Collaborative for Health. ■

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 is expected 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 and Support of System Change Grants

Project No: HHSM-500-2004-00055C
Project Officer: Cathy Cope
Period: September 2004 to September 2009
Funding: $1,496,495.00
Principal Investigator: Janet O'Keefe
Edith Walsh
Award: Contract
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

Description: The purpose of this contract is to conduct formative and summative research and evaluation of 2004 Real Choice Systems Change (RCSC) Grants

including Comprehensive Family to Family, Housing, Life Accounts, Mental Health System Transformation, Portals from Early Periodic Screening, Diagnosis, and Treatment (EPSDT) to Adult Supports, Rebalancing, and Quality Assurance and Quality Improvement in Home and Commmunity based services. ■

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 will be posted on the CMS web site in late 2009 or early 2010.

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 3M 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 June 2010
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 evaluator has prepared preliminary reports describing patient satisfaction, provider satisfaction, reasons for disenrollment, quality of life, clinical outcomes (hospitalization, transplant referral and survival), and cost analyses. The final report is expected in June 2010.

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 September 2010
Funding: $2,068,665.00
Principal Investigator: Jerry Cromwell
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. Two sites, Beth Israel NY, and Charleston, WV, are participating. The comparison hospitals for each site have been selected. The first wave of site visits is planned for early 2010. 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 2010
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 site visits to 9 home health agencies and has completed the project report for the site visits. The site survey instrument has been cleared by OMB and is currently in the field. The evaluation contractor has also begun the baseline analyses.

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 4 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 July 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 assessment reports are complete. The quantitative assessement is in progress.

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 Advantage Special Needs Plans

Project No: 500-00-0033/0013
Project Officer: Susan Radke
Period: September 2005 to December 2008
Funding: $1,005,970.00
Principal Investigator: Robert Schmitz
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Evaluation of the Special Needs Plan Report to Congress was cleared and submitted to Congress on October 30, 2008. The Summary Report on the Evaluation can be found on the CMS website at: http://www.cms.hhs.gov/reports/downloads/Schmitz_2008.pdf.

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

Evaluation of Medicare Health Care Quality Demonstrations - Phase I

Project No: 500-00-0024/0022
Project Officer: David Bott
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. A no-cost extension was recently granted with the contract to end 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 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: 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. Currently the project is using secondary data sources to conduct additional data analysis on utilization characteristics of the target population.

Description: This project supports a congressionally mandated evaluation of a demonstration required under the 2003 Medicare Modernization Act. Section 702, "Demonstration Project to Clarify the Definition of Homebound," requires the Secretary of Health and Human Services to conduct a 2-year demonstration to test the effect of deeming certain beneficiaries homebound for purposes of meeting the Medicare home health benefit eligibility requirement that the patient be homebound. Under the law, the demonstration is to be conducted in 3 states (representing Northeast, Midwestern, 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: $1,077,711.00
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 7/1/2009. The demonstration facilities and comparison facilities have been selected. Phase 2 has begun and data are being compiled for the baseline period.

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 March 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 Case Study Report, dated September 2008, has been completed and can be found at: http://www.cms.hhs.gov/Reports/downloads/Tanamor.pdf. The Focus Group report has been submitted to CMS and is in the process of being placed on the web.

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 examines early patterns of enrollment and the development of the MSA market in Medicare. The task order also includes an option to conduct a survey of beneficiaries to compare determinants of plan choice, service utilization, and out-of-pocket spending between MSA participants and beneficiaries enrolled in traditional Medicare and MA plans. ■

Evaluation of National DMEPOS Competitive Bidding Program

Project No: 500-00-0032/0014
Project Officer: Ann Meadow
Period: September 2005 to September 2010
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 the site visits they conducted. The contractor is adjusting the project plan in response to the program delay mandated by MIPPA. A revised data collection submission under the Paperwork Reduction Act was scheduled for announcement on Dec. 18, 2009. The package details revisions to the data collection areas, data collection instruments, and analysis plans.

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.hhs.gov/Reports/Downloads/McCall2008.pdf), provides interim findings on the first 18 months of the pilot programs. The evaluation is ongoing and will continue to assess the pilots through the end of operations. The final Phase I results will be presented to Congress in a third report, expected in February 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 Pilot Program for National State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities or Providers

Project No: 500-00-0015/0003
Project Officer: Beth Benedict
Period: September 2005 to June 2009
Funding: $999,938.00
Principal Investigator: Alan White
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: A task order to conduct the evaluation was awarded to Abt Associates, Inc. in September 2005. The project was extended to June 30, 2009. The demonstration was completed in September 2007. The report is complete and is on the CMS Web site. The contract was completed and closed on June 30, 2009.

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

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

Project No: 500-00-0033/0002
Project Officer: Lorraine Johnson
Period: September 2002 to October 2008
Funding: $2,373,740.00
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: Work under this contract is completed. The Report to Congress, dated February 14, 2008, has been delivered to Congress. The LifeMasters final evaluation

report has been posted on CMS website. The evaluation of the extension period falls under a new/separate contract (HHSM-500-2005-00025I/0011).

Description: Congress authorized the demonstration of disease management programs to evaluate whether disease management in conjunction with a prescription drug benefit would improve care quality, health outcomes, and reduce Medicare expenditures for fee-for-service Medicare beneficiaries with congestive heart failure, coronary artery disease, or diabetes. Three disease management programs were selected to participate. The demonstration ended prematurely. None of the programs impacted the key outcomes of Medicare Part A and B expenditures and service use. Impacts on quality of care were small and limited to a few measures and observed only for one program. The pharmacy benefit did not have the anticipated impact on improving access to medications nor did its combination with disease management services have a positive impact on health care expenditures and quality of care. The evaluation of the three-year LifeMasters Disease Management Demonstration Program was completed 10/31/08. The program did not achieve cost neutrality overall but came close for certain periods toward the end of the demonstration. CMS approved the first year of a potential three-year extension through December 31, 2008. The remaining two years will be approved based on LifeMasters' performance during the previous year. ■

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 is preparing case studies of the original 9 hospitals enrolled in the demonstration. The Report to Congress is due six months after the end of the 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 Second Phase of Oncology Demonstration Program

Project No: HHSM-500-2006-00009I/0002
Project Officer: Pauline Karikari-Martin
Period: August 2006 to May 2009
Funding: $654,447.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is complete. The final report is posted on CMS' web site for public viewing.

Description: This task order will evaluate how oncologists and hematologists adapted their practice in response to the CMS payment incentive, and to understand lessons learned for future demonstration projects involving oncologists and all specialists. The contractor will be required to design and conduct the evaluation of this demonstration. The evaluation will include collecting and analyzing primary and secondary data to examine issues that pertain to participation in this demonstration and system changes made within the physician office. Primary data will be collected from three sources: focus groups, site visits, and formal surveys. Secondary data will come from the CMS claims/billing system. This evaluation project offers a unqiue opportunity to capitalize on a nationwide demonstration, which involves data collection on how physician practices respond to financial incentives to collect and

report data which is not normally collected on the claim form. ■

Evaluation of the Cancer Prevention and Treatment Demonstration

Project No: 500-00-0024/0027
Project Officer: Karyn Anderson
Period: September 2005 to September 2010
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 is due to Congress September 2010. A final report will also 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 treament modalities, use of health services, the cost-effectiveness of each demonstration project, the quality of services provided, and beneficiary and provider (e.g., patient navigators/ case managers/treatment facilitators as well as clinical staff) satisfaction. Six demonstration sites have received awards (Baltimore, Detroit, Hawaii, Houston, Newark, and 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 IV 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 6-month review circulation for OMB approval in February 2006. OACT has just reviewed and approved, without revision, the contractor's proposal for the budget neutrality determination, as contained within the drafted Design Report. Currently underway is finalization of plans for impending selection of the four control regions and for the analysis of Medicare Claims data. The final phase (Phase Two) has been extended nine months, until 6/30/2010. 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, is in final stages of circulation.

Description: This Task Order is to assess the feasibility and advisability of expanding the coverage of chiropractic services under the Medicare program. The evaluation shall be conducted to: 1) Determine whether diagnostically 'eligible' beneficiaries who avail themselves of the expanded chiropractic services within the four demonstration treatment regions (i.e., 'users') utilize relatively lower or higher amounts of items and services 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 remibursable 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; and 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: Jennifer Schore
Lorenzo Moreno
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: Phase 2 of the demonstration was canceled by the American Recovery and Reinvestment Act of 2009 (ARRA). Phase 1 started June 1, 2009. The following deliverables are completed: the evaluation design report; the modification of the DOQIT office systems survey;

development of scoring methodology and validation plan; protocols for site visits, interviews of practices that withdrew, and interviews of community partners; and above tools undergoing PRA/OMB review.

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 up to 12 sites, that provide primary care to Medicare FFS beneficiaries with Diabetes, Coronary Artery Disease, Congestive Heart Failure, and other chronic diseases. The demonstration was planned initially to be conducted in two phases with four sites becoming operational in June 2009 and the remainder in June 2010. ■

Evaluation of the Erickson Advantage CCRC Demonstration

Project No: HHSM-500-2006-00010I/0001
Project Officer: Gerald Riley
Period: August 2006 to November 2008
Funding: $375,564.00
Principal Investigator: Andrea Ptaszek
Award: Task Order (XRAD)
Awardee: Pacific Consulting
PO Box 42026
Palo Alto, CA 94306

Status: The contractor submitted a draft final report in September 2008 and has completed revisions to the report based on comments received. The final report was delivered and the project is now complete.

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

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

Project No: HHSM-500-2005-00029I/HHSM-500-T0002
Project Officer: David Bott
Period: April 2009 to April 2013
Funding: $230,000.00
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. The contractor is conducting site visits to the three programs' original sites and is planning visits to expansion sites as they are proposed and approved. The contractor is also in the process of developing the comparison group populations per agreement with the demonstration programs.

Description: The Care Management for High Cost Beneficiaries (CMHCB) Demonstration, started in October 2005, provides disease management services for thousands of beneficiaries. The Centers for Medicare & Medicaid Services (CMS) awarded six organizations a 3-year demonstration project. The principal objective of this demonstration is 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 3 years with annual renewals

subject to quarterly finiancial evaluation of performance. This task order will continue 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 shall assist CMS in the design features of the extended and potentially expanded programs to assure that a suitable control group is identified. The evaluator will also revise 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: $545,199.00
Principal Investigator: Jennifer Schore
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The drafted fourth and final Report to Congress on the Extended MCCD demonstration, due to Congress by 4/30/2010, was entered into the CMS/HHS circulation review process during October 2009.

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 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 characeristics 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 Informatics, Telemedicine, and Education Demo - Phase II

Project No: HHSM-500-2004-00022C
Project Officer: Carol Magee
Period: September 2004 to March 2009
Funding: $970,711.00
Principal Investigator: Lorenzo Moreno
Arnold Chen
Award: Contract
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The demonstration stopped following patients in winter 2007. The Final Report to Congress from this evaluation was provided to Congress in January 2009. This contract ended on 3/27/2009.

Description: This contract for a second 4-year evaluation (Phase II, 2004 - 2008) of the IDEATel telemedicine diabetes demonstration (both of which were extended by the MMA 2003 into a Phase II, covering an additional 4 years) is essentially a follow-up of the evaluation done during Phase I of IDEATel, 2000-

2004, under the BBA 1997. Please refer to the Phase I evaluation contract number 500-95-0055, task order 5 for background information. This Phase II evaluation will not only cover the 4 years of IDEATel's Phase II progress and outcomes between 2004 and 2008, but will also provide summary evaluation results across the entire 8 years of the demonstration's existence. ■

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

Project No: HHSM-500-2005-00025I/0011
Project Officer: Lorraine Johnson
Period: August 2008 to February 2012
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 acheiving budget neutrality over the remaining demonstration period. The evaluation contractor will submit a final evaluation report by November 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 is January 1, 2008 - December 31, 2010. For the extension, the evaluation contractor will be required to submit an interim summary report and a final report to CMS based on claims analysis. The reports will include 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 September 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. A Report to Congress was drafted and is under review. Results of the demonstration will be made public once the Report is submitted to Congress.

Description: The purpose of this task order is to conduct the evaluation of the Medical Adult Day-Care Services Demonstration. Under this demonstration, which was mandated by Section 703 of the Medicare Modernization Act of 2003, Medicare beneficiaries who qualify for the Medicare home health benefit will be allowed to receive a portion of their home health nursing and therapy services in a medical adult day care facility, instead of their home. In September 2005, a task order was awarded to Brandeis University, Institute for Health Policy, to conduct the evaluation. This task order consists of three phases. Phase 1 will last 18 months and will include finalization of the evaluation plan, most of the qualitative analyses, and preliminary activities related to the quantitative analysis. Phase 2 will follow immediately after Phase 1 and will last for 30 months. The bulk of the quantitative analysis is expected to be done during Phase 2, at the end of which the Final Report will be delivered to CMS. Finally, Phase 3 will consist of an optional, extended period of 12 months, during which the task holder will remain available to make revisions to the Report to Congress, as required during the federal review process, and address inquiries as needed. ■

Evaluation of the Medicare 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 project is in its very early stages. Work has begun on identification of hospital-beneficiary control groups.

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 for High Cost Beneficiaries Demonstration

Project No: 500-00-0024/0025
Project Officer: David Bott
Period: September 2005 to September 2009
Funding: $1,784,544.00
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: This contract is in its final year of performance. An extension of the period of performance to September 29, 2010 was granted because the final demonstration program's operations end date was later than anticipated when the evaluation contract was awarded. All six demonstration sites have now completed the original demonstration operations or have ended early. The evaluation contractor has completed all site visits and the beneficiary survey for those six programs and the preliminary results of those evaluation activities have been made available when possible in the second and third annual reports. Claims data collection will continue up to 9 months after the end of the operating period of each program (the last program ended July 31, 2009). As claims data collection is completed for a given site, the contractor is conducting the final evaluation analyses and developing a final evaluation report for each of the six programs separately. The two programs that ended early will have those final reports available by January, 2010. The remaining four programs will have their final reports made available as they are completed and approved. The contract final report will be completed by September, 2010.

Description: The purpose of this project is to design and initiate the evaluation of the "Care Management for High Cost Beneficiaries" (CMHCB) demonstration programs as implemented in the Medicare program. The six awarded demonstration sites implement and operate a care management demonstration serving high-cost beneficiaries in the original Medicare fee-for-service (FFS) program. CMS contracted with RTI, Inc. to study the design and implementation of these programs and to evaluate the experience of the intervention group in each program compared to the relevant control group to ascertain the ability of each program and individual elements of each program to improve clinical quality, achieve high levels of beneficiary and provider satisfaction, promote efficient use of health care services, and produce savings for Medicare in the intervention group. Under this contract the evaluator shall assist CMS to assure that a suitable control group is identified and to design and execute the specific evaluation plan. ■

Evaluation of the Medicare Care Management Performance Demonstration

Project No: HHSM-500-2005-00025I/HHSM-500-T0001
Project Officer: Lorraine Johnson
Period: September 2009 to September 2010
Funding: $471,513.00
Principal Investigator: Lorenzo Moreno
Award: Task Order (MRAD)

Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: Draft interim evaluation report is in review process. The Office systems survey was implemented in early December 2009.

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 implementatin 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 2009
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 was extended to 12/31/2009. The implementation report was completed 3/4/09 and was posted on the CMS website. The beneficiary and physician surveys are underway. The office systems survey will begin in early December 2009. An interim evaluation report is in the review process. A new contract (HHSM-500-2005-00025I/HHSM-500-T0001) was awarded on 9/21/09 to cover the last 27 months of the evaluation.

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 Medical Home Demonstration

Project No: HHSM-500-2005-00029I/0016
Project Officer: 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: Design of the evaluation is under way. 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 3-year demonstration is authorized by Section 204 of the Tax Relief and Health Care Act of 2006 and 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 8 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 stake holder groups will be completed by January of 2010.

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 May 2010
Funding: $995,434.00
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: Several 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." Both of these reports are posted on the CMS Web site. Two additional reports have been completed as of November 2008: 1) Part D Payment Demonstration Evaluation Plan Benefit Design Analysis; and 2) Part D Payment Demonstration Enrollment Analysis. Additional reports on program costs and the final summary are in progress and will be completed by May 2010.

Description: This project focuses on evaluating the impact of the Medicare Part D payment "reinsurance" demonstration. CMS has announced its intent to conduct a demonstration that represents an alternative payment approach for private plans offering prescription drug coverage under Part D. The demonstration is expected to increase the number of offerings of supplemental prescription drug benefits through enhanced alternative coverage. The purpose of this demonstration is to "allow private sector plans maximum flexibility to design alternative prescription drug coverage." This evaluation examines the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs), and Medicare program costs. From the beneficiary perspective, the evaluation focuses on the availability of, and enrollment in, enhanced alternative benefit packages offered by drug plan sponsors, as well as enrollees' patterns of utilization. The evaluation also explores the advantages and disadvantages of participation from the perspective of drug plan sponsors and the Medicare program. Both primary (site visits, focus groups) and

secondary CMS data sources are being used in the evaluation of this demonstration. ■

Evaluation of the Premier Hospital Quality Incentive Demonstration

Project No: HHSM-500-2005-00029I/HHSM-500-TO003
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 underway. 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 Congres 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 September 2010
Funding: $400,232.00
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. A Report to Congress is due at the end of September 2010.

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 communtiy 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: $1,009,720.00
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 site visit draft 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 third year. Currently there are seven (7) 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 seventeen (17) 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 third year. Currently there are twelve (12) 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 DriveSuite 505
Falls Church,VA 22042

Status: This is an umbrella contract and is in its third year. Currently there are four (4) 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 third year. Currently there are eleven (11) 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 third year. Currently there is one (1) task order awarded under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of 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: Mary Sowers
Period: September 2007 to September 2011
Funding: $553,060.00
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 with 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. ■

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: Donna Frescatore
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 continues to implement its planned health care system reforms. The demonstration was amended in January 2010, to provide 12-months continuous eligibility for most individuals enrolled in the demonstration, as well as to require managed care enrollment for individuals living with HIV.

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

Florida Family Planning Waiver

Project No: 11-W-00135/ 04
Project Officer: Juliana Sharp
Period: August 1998 to March 2010
Funding: $ 0.00
Principal Investigator: Carlton Snipes
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: On October 8, 2009, Florida requested a 3-year extension for the demonstration. As of November 30, 2009, 82,863 individuals received family planning services through 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, CHIP, 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: Carlton Snipes
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: The demonstration currently is operating in five counties (Broward, Duval, Baker, Clay, and Nassau). Approval by the Florida legislature is required for further expansion. Florida has requested to amend the demonstration to allow expenditures relating to certain 1915(b)(3) services and to decouple access to LIP funds from statewide expansion.

Description: Under the Florida Medicaid Reform demonstration, participation in managed care is mandatory for Temporary Assistance to Needy Families (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 establishes 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 2010
Funding: $ 0.00
Principal Investigator: Carlton Snipes
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , FL 32308

Status: Florida requested a three year extension of the demonstration on December 30, 2009. The request is currently pending.

Description: The Florida MEDS for Aged and Disabled (MEDS-AD) demonstration provides coverage for certain aged and disabled individuals with incomes up to 88% Federal Poverty Level (FPL). This optional Medicaid eligibility group was eliminated from the state plan in 2005. Enrollees receive services through the same delivery systems as the traditional Florida Medicaid program. The objective of the demonstration is to evaluate the impact of providing high intensity pharmacy case management for individuals with a large volume of routine medications. The demonstration will be funded through savings generated from avoiding high cost institutional placement that would occur in the absence of pharmacy and medical services. ■

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 at http://cms.hhs.gov/Reports/Downloads/MaCurdy_RxGeoPrice_RTC_2009.pdf. The final report from the project is available at: 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. ■

Hawaii QUEST Expanded

Project No: 11-W-00001/09
Project Officer: Steven Rubio
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: The QExA component of the demonstration was implemented on February 1, 2009.

Description: Hawaii's QUEST Expanded demonstration extends Medicaid coverage to additional children and adults, through the creation of a public purchasing pool that arranges for health care through capitated managed care plans. This demonstration builds upon the Hawaii Prepaid Health Care Act, an Employee Retirement Income Security Act (ERISA) waiver, which requires all employers to provide insurance coverage to any employee working more than 20 hours per week. Title XIX funded coverage is offered to several groups who are not eligible under the Medicaid state plan, including Temporary Assistance for Needy Families (TANF) cash recipients who are otherwise ineligible for Medicaid and childless adults, with incomes up to 100% of the Federal Poverty Level (FPL). Expanded title XIX coverage is funded through savings from managed care and the

reallocation of funds formerly used to provide payment adjustments to disproportionate share hospitals. CHIP-eligible children also receive their coverage through the delivery system created by QUEST Expanded. In February 2008, CMS extended the demonstration for 5 years under section 1115(a) because Hawaii substantially expanded the demonstration by the addition of the Quest Expanded Access (QExA) program. Under QExA, four of Hawaii's home and community based services (HCBS) waivers and all long-term care services for the aged, blind, and disabled (ABD) populations are included in the demonstration. Long-term care and acute care medical services are provided using an integrated managed care delivery system. ■

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 was extended with no additional costs until 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 has started work on the project. An annual report is due in August 2010.

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 Service Delivery (HSD) Reform Mapping Project

Project No: HHSM-500-2005-00024I/0003
Project Officer: Daniella Stanley
Serrick McNeill
Period: September 2008 to September 2009
Funding: $669,426.00
Principal Investigator: Ann Osborn
Award: Task Order (XRAD)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: The period of performance was extended through August of 2009. The project is now complete.

Description: This contract will include tasks that highlight research on employer group plans in the current market, reviews of transitioning Private Fee-for-Service (PFFS) applications, development of Special Needs Plan (SNP) network criteria, and research on mature Medicare Managed Care markets and Regional Preferred Provider Organizations (RPPO) reviews. ■

Healthier Mississippi

Project No: 11-W-00185/04
Project Officer: Mark Pahl
Period: September 2004 to March 2010
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: Since October 2009, the demonstration operated under a series of temporary extensions and is currently on temporary extension, pending consideration of the state's request for a three-year extension through September 30, 2012.

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 Mississippi'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: Jeffery Wells
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: In 2009, Indiana submitted requests to amend the demonstration to add two new projects to the list of required cost-savings projects, to raise the limit on nursing facility care in the HIP benefit from 30 to 60 days, to change how the state's DSH allotment is allocated between demonstration expenditures and payments to hospitals, to change eligibility parameters for the Enhanced Services Plan, and to raise the member enrollment cap on HIP childless adults from 34,000 to 36,500. Consideration of these changes is pending.

Description: The Healthy Indiana Plan demonstration provides health insurance coverage (HIP coverage) to uninsured adults with family incomes up to 200% Federal Poverty Level (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, as well as 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 covarage must make a monthly contribution to their POWER account, which is determined based on income, on a sliding scale. 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, Indiana 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.

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 Datalink File--Phase III

Project No: HHSM-500-2004-00153G
Project Officer: Ann Meadow
Period: September 2004 to April 2009
Funding: $564,971.00
Principal Investigator: Edward Fu
Award: Inter-agency Agreement
Awardee: Fu Associates
2300 Clarendon Boulevard, Suite 1400
Arlington, VA 22201

Status: Under the direction of CMS, the contractor conducted data analyses to refine specifications for the analytic files. In January 2005, the contractor delivered a 100 percent file of home health PPS payment episodes through June 2004 with detailed edited and derived variables summarizing utilization and payment information internal to the claim. Additional variables summarize information from external sources, including inpatient claims files, enrollment data, Area Resource File data, and Provider of Service File variables. The episodes are uniquely linked to several ancillary files containing details on related inpatient stays, OASIS and other patient assessments, and other information. The files are being used in several intramural and extramural studies and evaluations in CMS and DHHS. Updates of the file with additions and enhancements were delivered in 2006, 2007, 2008, and 2009. The contract terminated in 2009.

Description: The Balanced Budget Act of 1997 mandated dramatic changes in several areas of Medicare services, including the home health benefit. The Act mandated a home health prospective payment system (PPS), to be preceded by an interim payment system (IPS) until the PPS could be implemented. In place from late 1997 to October 2000, the IPS led to sharp reductions in the numbers of home health agencies and home health utilization by Medicare beneficiaries. The PPS was implemented in October 2000, and refinements to the system were applied in 2008. Policymakers want information on the full impact of this succession of changes. Therefore, data development for such studies is needed by the Department and will be in demand by external researchers and policymakers. Under this project, the contractor annually provides a comprehensive, data-analytic file covering the entire PPS period to date. The file serves the medium-term needs of policymakers regarding the Medicare home health benefit. In addition, the file will meet the internal needs of CMS and the Department in the areas of payment refinements, quality improvement, and program integrity. The contractor is also tasked with providing certain technical assistance and analytical programming support using the products of the contract. ■

Home Health Demonstrations: Technical Support

Project No: 500-00-0032/0009
Project Officer: Bertha Williams
Period: July 2004 to September 2009
Funding: $1,331,399.00
Principal Investigator: Henry Goldberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The 2-year Home Health Independence Demonstration was implemented beginning October 4, 2004 and ended October 4, 2006. The Medical Adult Day Services Demonstration was implemented in five sites on August 1, 2006 and ended July 31, 2009.

Description: The purpose of the Home Health Demonstrations Technical Support contract is to assist CMS with the design, implementation, and operation of two home health demonstrations mandated under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The first is the demonstration project to clarify the definition of "homebound", mandated under Section 702 of the MMA. In this demonstration, Medicare beneficiaries with permenant, debilitating disabilities who met specific criteria were allowed to receive needed home care and leave home as often and as long as they wished and still be considered homebound. Three States were selected for the demonstration, Missouri, Colorado and Massachusetts. All home health agencies in these States were eligible to participate in the demonstration. The second demonstration, the Medical Adult Day Care Services Demonstration was mandated under Section 703 of the MMA. In this demonstration home health agencies are permitted to provide beneficiaries with the option of receiving a portion of their needed home care in a medical adult day care facility. The demonstration was restricted to the selection of 5 sites, i.e. home health agencies, in States that license or certify medical adult day care facilities. ■

Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00018I/0004
Project Officer: James Coan
Period: September 2006 to March 2009
Funding: $542,231.00
Principal Investigator: Henry Goldberg
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The contractor developed a detailed Home Health Pay-for-Peformance Demonstration design, which CMS has implemented. Recruitment of home health agencies began on October 5, 2007. 567 home health agencies in 9 states have voluntarily enrolled to participate in the demonstration as either an intervention or a control site. The first year of P4P services is being analyzed and the savings are being calculated. If there are savings they will be shared with participating agencies in the top 20% of performers or quality improvers from the intervention group in the states where the savings occurred. If there are no savings no payments will be made.

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

Home Health Third Party Liability Demonstration Arbitration

Project No: HHSM-500-2005-00033I
Project Officer: Juliana Tiongson
Period: September 2005 to September 2010
Funding: $1,262,000.00
Principal Investigator: S. Paret
Award: Contract
Awardee: American Arbitration Association
601 Pennsylvania Avenue, NW
Washington, DC 20004-2676

Status: CMS has obtained legal representation during the arbitration hearings. Hearings covering Fiscal Year 2001 cases concluded in November 2008. Funding for this Indefinite-Delivery Indefinite-Quanity contract has increased by $499,000, from $763,000 to $1,262,000. Arbitration hearings have been on hold since December of 2009.

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 adevice from healthcare professionals on matters related to end-of-life care; and a webcast related to cancer and end-of-life care. The following tasks are in development for the grant: 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 includeing 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 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 2010
Funding: $714,874.00
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: The project is underway. This project also includes four additional one-year options after the end date.

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 progam 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 March 2010
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. Discussions continue on a possible longer-term extension of the Children's Access Card component.

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 for Employer-Subsidized Insurance (ESI) coverage to uninsured pregnant women with incomes between 133% and 185% Federal Poverty Level (FPL) not eligible for Medicaid, and uninsured parents of children who are eligible for Medicaid or CHIP with incomes up to 185% Federal Poverty Level (FPL). ■

Illinois Family Planning

Project No: 11-W-00165/05
Project Officer: Juliana Sharp
Period: June 2003 to March 2012
Funding: $ 0.00
Principal Investigator: Theresa Eagleson-Wyatt
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: On December 29, 2009, the demonstration was approved for an extension through March 31, 2012. As of January 11, 2010, 142,378 individuals were enrolled in 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 Health Insurance Flexibility and Accountability (HIFA) Waiver demonstration and have family incomes at or below 200% Federal Poverty Level (FPL). ■

Impact of Increased Financial Assistance to Medicare Advantage Plans

Project No: 500-00-0024/0017
Project Officer: Melissa Montgomery
Period: August 2004 to December 2009
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-2007.pdf.

The 2007 and 2008 MA Monitoring Reports are in progress. Data issues required additional work on both reports. CMS anticipates finalizing these reports by 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, RTI 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: $1,333,834.00
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 due in March, 2010.

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 and Monitoring, Support of the Medicare Hospital Gainsharing Demonstration

Project No: HHSM-500-2006-00005I/0003
Project Officer: Lisa Waters
Period: August 2006 to August 2010
Funding: $1,792,012.00
Principal Investigator: David McKusick
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 now fully funded.

Description: This demonstration will provide a test of gainsharing in the Medicare program. It will determine if gainsharing can align the incentives between hospitals and physicians in order to improve the quality and efficiency of care. The goal is to improve hospital quality, while focusing on operational and financial performance. The contractor will provide overall implementation and monitoring support for the three year demonstration. All data collected and analyzed for real-time monitoring will subsequently be used for the evaluation; therefore the contractor will collaborate with the evaluation contractor to collect and store all data elements. The contractor shall be responsible for monitoring gainsharing arrangements to ensure all demonstration requirements are met 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 others work and avoid unnecessary duplication of tasks. ■

Implementation of ESRD Bundled Payment and Pay-for-Performance

Project No: HHSM-500-2006-00005I/0002
Project Officer: Henry Bachofer
Period: August 2006 to September 2011
Funding: $498,862.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The Demonstration was cancelled pursuant to §153(b)(3)(C) of MIPPA (Pub. L. 110-275).

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

Implementation of the Medicare Care Management Performance (MCMP) Demonstration

Project No: 500-2005-000291/0014
Project Officer: Jody Blatt
Period: August 2008 to September 2011
Funding: $149,993.00
Principal Investigator: Michael Trisolini
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. (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) will begin 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 originally awarded in 2003 to support the implementation and evaluation of the Physician Group Practice (PGP) demonstration, Medicare's first pay-for-performance initiative for physicians in large multi-specialty group practices. In 2005, the contract was modified to incorporate clinical quality measure data collection and related tasks for the Medicare Care Management Performance (MCMP) demonstration, a pay for performance demonstration for smaller primary care group practices in four states (Arkansas, Utah, California, 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 clincical quality measures related to the care of beneficiaries with diabetes, congestive heart failure, coronary artery disease, and preventive care services. In addition, they will be eligible to earn additional bonuses if the quality measure data is submitted electronically from a 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 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: $3,079,944.00
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 and the total estimated cost plus fixed fee was increased by $849,996 from $2,229,948 to $3,079,944.

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 third performance year, 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 28 out of the 32 quality markers for patients with diabetes, coronary artery disease, congestive heart failure, hypertension, and cancer screening. Over the first three years of the demonstration, physician groups increased their quality scores an average of 10 percentage points on the diabetes, 11 percentage points on the congestive heart failure measures, 6 percentage points on the coronary artery disease measures, 10 percentage points on the cancer screening measures, and 1 percentage point 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 $5.8 million. In addition, five physician groups earned $25.3 million in performance payments for improving the quality and cost efficiency of care as their share of a total of $32.3 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 $31.1 million in the third performance year. ■

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

Project No: HHSM-500-2005-00029I/0001
Project Officer: Henry Bachofer
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 demosntration design is complete. Work is now being transitioned to the development and implementation of procedures for financial reconciliation. It is estimated that the amount currently allotted will cover payment for the contractor's performance of work through 2010.

Description: The contractor will assist with design and implementation of individual demonstration projects, 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 2010
Funding: $818,719.00
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.

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 seven 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 August 2011
Funding: $689,088.00
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.

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 3-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 2014
Funding: $993,471.00
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 09/29/2009 until 09/28/2014. This contract was awarded for five years with annual incremental funding.

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 2 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, [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. ■

Implementing the HEDIS Medicare Health Outcomes Survey

Project No: HHSM-500-2004-00015I/0001
Project Officer: Sonya Bowen
William Long
Chris Haffer
Period: September 2004 to September 2009
Funding: $3,750,993.00
Principal Investigator: Kristen Spector
Award: Task Order
Awardee: National Committee for Quality Assurance
1100 13th Street, NW
Washington, DC 20005

Status: This period of performance has ended. The HOS is an ongoing annual survey and is continuing under Contract HHSM-500-2009-00051C. The HOS program has achieved national and international recognition as the largest collection in the world of robust health status measurements from the patients' perspective. Results have been presented at various national and international professional meetings and published extensively in peer-reviewed journals.

Description: The Centers for Medicare & Medicaid Services (CMS) is committed to the implementation of quality assessment processes in Medicare managed care organizations (MCOs). The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of defined measures developed by the National Committee for Quality Assurance (NCQA) to assess the health care quality provided by managed care plans. In 1998, HEDIS represented a significant extension in the range of health care services being evaluated, including an outcomes measure initially entitled the Health of Seniors. During the first year of implementation, CMS renamed the measure the Medicare Health Outcomes Survey to reflect the inclusion of disabled beneficiaries under the age of sixty-five. Section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandates the collection, analysis, and reporting of health outcomes information. This legislation also specifies that data collected on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration must utilize the types of data collected prior to November 1, 2003. Collected since 1998, the Medicare HOS is the only outcomes measure in Medicare managed care and therefore, remains a critical part of assessing health plan quality. ■

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: The project is underway.

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 new grant period is recently underway. An annual report on BCHIP is due by 12/31/2009. The final report for this grant is due 4/30/2011.

Description: This program will provide an umbrella administrative framework to fund services and adminstratively 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 extended at no additional cost until 12/31/2010.

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 is due to close 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 contract was modified to increase funding in May of 2009. The project is now coming to a close.

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. CMS intends to implement the new system by the end of 2008. Future improvements to the system will also be considered. ■

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 2010
Funding: $4,536,972.00
Principal Investigator: Laura Giordano
Award: GSA Order
Awardee: Health Services Advisory Group
1600 East Northern Avenue, Suite 100
Phoenix, AZ 85020

Status: Round twelve data submission, cleaning, and analysis from the 2009 HOS field administration will be completed in early 2010. Cohort ten performance measurements and cohort twelve baseline results will be finalized and made available later in 2010. Calendar Year 2010 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. ■

Increasing Access to Health Care for Bucks County Residents

Project No: 18-P-91506/03
Project Officer: Carol Magee
Period: September 2001 to September 2009
Funding: $3,339,750.00
Principal Investigator: Sally Fabian
Award: Grant
Awardee: Bucks County Health Improvement Project, Inc.
1201 Langhorne-Newton Rd
Langhorne, PA 19047

Status: This grant funding period ended on September 9, 2009. Many of these direct BCHIP medical and dental services are continuing, now funded under a new grant awarded on 8/30/2009 (1C0CMS030437/01) and under an expanded administrative umbrella that integrates these free clinics throughout Bucks County.

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

Indiana Disaster Relief

Project No: 11-W-00240/05 and 21-W-00060/05
Project Officer: Juliana Sharp
Period: August 2008 to August 2009
Funding: $ 0.00
Principal Investigator: Jeffery Wells
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: The demonstration ended on July 31, 2009.

Description: This demonstration was approved to assist Indiana in dealing with the consequences of severe flooding and storms affecting wide areas of the state. Under the demonstration, Indiana may continue Medicaid and CHIP eligibility without a redetermination of eligibility for individuals whose regular eligibility redetermination would have occurred between 6/9/2008 and 7/31/2008. The demonstration is in effect in 53 Governor-designated disaster counties. ■

Informatics for Diabetes Education and Telemedicine Demonstration (IDEATel)

Project No: 95-C-90998/06
Project Officer: Diana Ayres
Period: February 2000 to February 2009
Funding: $60,000,000.00
Principal Investigator: Steven Shea
Award: Cooperative Agreement
Awardee: Columbia University
630 West 168th St, PH 9 East, Room 105
New York, NY 10706

Status: In Phase I of the demonstration, the first nine months of the project were devoted to technical implementation, field testing, personnel training, and development of the evaluation instruments and procedures. After enrollment began and recruitment was completed, approximately 1,665 beneficiaries were enrolled and randomized. Overall acceptability of the home telemedicine unit among participants was positive. During Phase II, second and third generation HTUs were developed, tested, and installed in the homes of a few participants. Due to the inability of a key subcontractor to deliver Generation 2 or 3 HTUs, most participants were unable to experience the planned Phase II technological improvements in the newer units. The intervention ended for participants on February 27, 2007. CMS' independent evaluation of the demonstration indicates that large-scale home telemedicine as a strategy for disease management is technically feasible, can be performed in a fashion that meets current requirements for health care data security and the Health Insurance Portability and Accountability Act, and is acceptable to those who agree to participate. Regardless, this does not preclude the extent of training and reinforcement often necessary under these circumstances to elevate enrollees to an active and participatory level. Evidence indicates that some Medicare beneficiaries living in federally designated medically underserved areas, for reasons such as language barriers, lack of education, and various other socioeconomic indications, are unable or unwilling to use computers or the World Wide Web to obtain health care information and health care services. The evaluation found the demonstration to be clinically effective in only one of the two sites and to have no effects on Medicare Part A and Part B expenditures or the use of expensive services, such as hosptital care. The main driver of these costs was the size of the cooperative agreement allocated to the demonstration's operations, compounded with the use of very expensive HTUs. While an ongoing program similar to the demonstration could potentially have lower costs, it would be virtually impossible for such a program to generate cost savings, particularly because

the intervention-related costs of the demonstration were excessive by any standard. Given the absence of effects on costs or services, however, even a less expensive version of this demonstration would not produce sufficient Medicare savings to offset demonstration costs. The project is now complete.

Description: This project was mandated as a four year demonstration by Congress in the Balanced Budget Act of 1997. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress authorized an extension of the demonstration for an additional four years. In December 2007, CMS approved a 12-month no cost extension. The project focuses on Medicare beneficiaries with diabetes because of the high prevalence, cost, and complexity of this condition. It also focuses on beneficiaries living in federally designated, medically underserved areas in order to demonstrate that obstacles to bridging the "digital divide" in health care are not intrinsic to the targeted population. The project involves a consortium of health care delivery organizations in New York City (urban component) and upstate New York (rural component); industry partners who are providing hardware, software, technology, and communication services; and the American Diabetes Association, which is providing the educational website for the project. The consortium is led by Columbia University. Intervention participants receive a home telemedicine unit (HTU), which facilitates uploading of clinical data, interaction with a nurse case manager, and patient education. ■

Inpatient Rehabilitation Facility Classification System Analytic and Programming Support

Project No: HHSM-500-2006-00039C
Project Officer: Susanne Seagrave
Period: September 2006 to September 2010
Funding: $419,840.00
Principal Investigator: David Malitz
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

Status: The contract was modified to add a twelve month, no cost extension to the period of performance to allow for completion of the SNF grouper analysis for the FY 2011 SNF PPS final rule, to be issued on July 31, 2010.

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: The project is underway.

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. ■

Integrated Payment Option Support Contract

Project No: 500-00-0024/0006
Project Officer: Juliana Tiongson
Period: September 2002 to March 2009
Funding: $658,775.00
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: Several tasks under this contract were postponed and/or delayed. The contractor concentrated on the task of developing a Post Acute Integrated Payment demonstration to be implemented in the Mercy Medical network of post acute providers in Alabama. The system covered services provided in inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies. The contractor completed all tasks associated with the Post Acute Integrated Payment demonstration and provided some support for the Acute Care Episode (ACE) demonstration. The project is now complete.

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

Iowa Disaster Relief

Project No: 11-W-00239/07 and 21-W-00059/07
Project Officer: Juliana Sharp
Period: July 2008 to August 2009
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 ended August 31, 2009.

Description: This demonstration was approved to assist Iowa in dealing with the consequences of severe flooding and storms affecting wide areas of the state. Under the demonstration, Iowa may continue Medicaid and CHIP eligibility without a redetermination of eligibility for individuals whose regular eligibility redetermination would have occurred between 7/1/2008 (6/16/2008 in selected counties) and 8/31/2008. Iowa also received authority to treat individuals as institutionalized, or receiving home and community-based services (even though they receive less than 30 days of continuous care in the respective setting), and for relief from requirements for preadmission screening and resident review screenings, minimum data set screenings, and Intermediate Care Facility for the Mentally Retarded (ICF/MR) assessments. The latter authorities allowed Iowa to pay for nursing home or ICF/MR services for Medicaid eligible individuals dislocated by the flooding and who were seeking temporary shelter and services. ■

Iowa Family Planning

Project No: 11-W-00188/07
Project Officer: Juliana Sharp
Period: January 2006 to January 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 January 14, 2010, 30,064 individuals received family planning services through the demonstration.

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% Federal Poverty Level (FPL). ■

IowaCare

Project No: 11-W-00189/07
Project Officer: Juliana Sharp
Period: July 2005 to June 2010
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: In June 2009, Iowa requested that the prohibition on nursing facility provider taxes that appears in the demonstration's special terms and conditions be rescinded. On October 8, 2009, Iowa requested a 3 year extension. Both requests are pending. As of September 30, 2010, 34,518 expansion eligibles were served under the demonstration.

Description: IowaCare expands health insurance coverage to uninsured Iowans up to 200% FPL, eliminates Medicaid financing arrangements whereby providers do not retain 100% of claimed expenditure, provides home and community-based services to children with chronic mental illness, and moves towards community-based settings for 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 has yielded approximately $65 million in additional federal funds annually for Iowa 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: Elizabeth Johnson
Award: Waiver-Only Project
Awardee: Kentucky, Department of Medicaid Services
275 East Main Street, 6 West A
Frankfort, KY 40621

Status: As of September 30, 2009, 144,251 individuals received their Medicaid coverage through this demonstration.

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 project is underway.

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: Juliana Tiongson
Period: September 2006 to September 2011
Funding: $2,174,487.00
Principal Investigator: Arthur Bruegger
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. ■

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

Project No: HHSM-500-2004-00003I/0006
Project Officer: Ronald Deacon
Period: March 2005 to March 2009
Funding: $207,199.00
Principal Investigator: Donna Mason
Award: Task Order
Awardee: Destiny Management Services, LLC
8720 Georgia Avenue
Silver Spring, MD 20910

Status: No meetings of the ESRD Advisory Board were held in 2007, nor in 2008. In 2008, section 153 of the Medicare Improvements for Patients and Providers Act of 2008 repealed the original legislation directing the Secretary to undertake the bundled payment demonstration. Consequently, the Federal Advisory Committee was terminated in late October 2008. The Contract for Logistical Support ended on March 20, 2009.

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

Long Term Care Hospital Payment System Refinement/Evaluation

Project No: 500-00-0024/0020
Project Officer: Judith Richter
Period: September 2004 to December 2008
Funding: $931,021.00
Principal Investigator: Barbara Gage
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The contract was modified to increase the level of effort to develop an instrument for establishing patient and facility level criteria for LTCHs. A no cost extension with an ending date of 12/31/2008 was approved on 9/10/2008. The final report on this project has been submitted and the contract is complete.

Description: The contractor shall provide a wide variety of statistical data and policy analysis to evaluate the long-term acute care hospital (LTCH) prospective payment system (PPS) and its effect on overall Medicare payments and also to determine the feasibility of CMS establishing facility and patient level criteria for LTCHs. ■

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: A draft manuscript is under review for possible publication.

Description: The objective of the study is to update previous research on the cost of Medicare services in the last year of life and identify long term trends. The study is 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: Thomas Hennessy
Period: June 2006 to August 2011
Funding: $ 0.00
Principal Investigator: Jerry Phillips
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 January 1, 2010, 65,662 individuals received family planning services through the demonstration.

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

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 5-years. The demonstration is occurring in New Hampshire, the greater New York City metroploitan area including all 5 boroughs, North Carolina, the greater Atlanta metropolitan area, Georgia, Kansas, and Washington state.

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

Maine Care for Childless Adults

Project No: 11-W-00158/01
Project Officer: Thomas Hennessy
Period: September 2002 to September 2010
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: Maine requested a three-year extension on September 30, 2009. As of that date, 11,720 childless adults received coverage under this demonstration.

Description: This demonstration extends coverage to childless adults and non-custodial parents with incomes up to 100% Federal Poverty Level (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: Thomas Hennessy
Period: February 2000 to June 2010
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: As of January 12, 2010, 678 individuals participated in the demonstration, of which 353 were Medicaid eligibles receiving enhanced care management services and 325 were expansion eligibles who receive all of their coverage through the demonstration.

Description: This demonstration extends health care and prescription drug benefits to individuals with HIV/AIDS, who have incomes up to 250% of the FPL, and who are not otherwise eligible for Medicaid. Many of these individuals would eventually become disabled due to the natural progression of the disease and thus, qualify for full Medicaid coverage. By providing a targeted package earlier in the process, Maine 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: Camille Dobson
Period: October 1996 to June 2011
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: Maryland submitted two amendment requests in fall 2009, which are under review. The first is a program to provide discounted prescriptions to uninsured individuals with incomes up to 300% FPL; the second would incorporate the existing state-funded Maryland Health Insurance Plan, a health insurance premium subsidy program, into the demonstration. Both amendment requests are under consideration.

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 whom are eligible for family planning services only, individuals age 19 and over with income below 116% Federal Poverty Level (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: Thomas Hennessy
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 thirteenth year and covers more than one million low-income individuals across the Commonwealth. With the help of this demonstration, Massachusetts has the highest health insurance coverage rate in the country, holding at around 97% of the population.

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 (SNCP). The IP program is an employer sponsored insurance (ESI) program, which provides a subsidy for employers with 50 or fewer employees as long as the employer contributes at least 50 percent of the total premium for the employee and any dependents. In addition to managed care savings, funds formerly used to make payment adjustments to disproportionate share hospitals (DSH) also are used to provide health care coverage. On April 12, 2006, Massachusetts 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 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 January 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: Abt Associates will continue 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 to January 2010.

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 and a MAXPM design report. The contractor is currently working on the prototypes for each new file.

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 Master (MAXPM) 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 MAXPM file is another MAX enhancement activity under Option Task 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#TopOfPage ■

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 status' 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 at: www.cms.hhs.gov/twwiia. ■

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 status' 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 at: www.cms.hhs.gov/twwiia. ■

Medicaid Statistical Information System (MSIS) Data Quality Support

Project No:	HHSM-500-2005-00025I/0009
Project Officer:	Denise Franz
Period:	September 2008 to September 2010
Funding:	$2,962,746.00
Principal Investigator:	Suzanne Dodds
Award:	Task Order (RADSTO)
Awardee:	Mathematica Policy Research (Cambridge) 50 Church Street Cambridge, MA 02138-3726

Status: Mathematica (MPR) continues to peform 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. The contract was reawarded to MPR in September 2008 and includes two option years after FY 2009. The contract has been modified to add an addendum to the Statement of Work to include tasks related to the CHIP program data.

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 Adult Day Care Services Demonstration

Project No: ORDI-05-0005
Project Officer: Bertha Williams
Period: August 2006 to September 2009
Funding: $431,400.00
Principal Investigator: Henry Goldberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Proposals from potential applicants were solicited through a notice published in the Federal Register on June 24, 2005, with applications due on September 24, 2005. Final site selection was completed May 2006. Implementation of the demonstration began August 1, 2006. The five sites are: Aurora Visiting Nurses Association, Milwaukee, Wisconsin; Doctor's Care Home Health, McAllen, Texas; Landmark Home Health Care Services, Allison Park, Pennsylvania; Metropolitan Jewish Health System, Brooklyn, New York; and Neighborly Care Network, St. Petersburg, Florida. The Metropolitan Jewish Health System ended active participation in the demonstration March 20, 2008. Aurora Visiting Nurses Association of Wisconsin ended its active participation in the demonstration October 30, 2008. Abt Associates, as the support contractor, continued to assist CMS in the management and monitoring of the demonstration sites through July 2009. In order to have more accurate numbers and verification of patient participation, Abt Associates was granted a "no cost extension of its contract through September 15, 2009. The project is now complete.

Description: Section 703 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) directs the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. The demonstration was limited to five sites in states that license or certify medical adult day care facilities. Under the demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The demonstration will run for a period of 3 years and will be conducted through no more than 5 home health agency sites in states selected by CMS. Up to 15,000 beneficiaries may participate in the demonstration at any one time. Abt Associates was competitively awarded The Home Health Support Contract to provide assistance to CMS in the implementation and management of the Medical Adult Day Care Services Demonstration. ■

Medical Home Demonstration Design Contract

Project No: HHSM-500-2005-00025I/0005
Project Officer: James Coan
Period: September 2007 to April 2009
Funding: $333,781.00
Principal Investigator: Deborah Peikes
Award: Task Order
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor has prepared 6 option papers defining the components of medical home, patient and practice eligibility requirements, payment methodology, shared savings calculation methodology, site selection, and recruitment and monitoring of physician practices. Final demonstration design was submitted in June 2008. This contract has ended.

Description: This Task Order will provide assistance to CMS in the design of the Medical Home Demonstration. Contractors will assist CMS in providing design specifications for the demonstration, including a detailed definition of a medical home, site selection criteria, waiver cost estimate, and an appropriate and feasible overall design for the demonstration. ■

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 ot 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 8 states including urban, rural and underserved areas, over a 3-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 submitterd 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: Nancy McCall
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Currently, two of the five selected sites have implemented the 3-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 network continues to develop it's operational protocols and financial model for delivery to CMS later this year.

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: $4,817,250.00
Principal Investigator: Jean Orelein
Award: Contract
Awardee: SciMetrika, LLC
100 Capitola Drive Suite 104
Durham, NC 27713

Status: The MCPSS is underway. This 5-year contract will expire August 23, 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

Project No: HHSM-500-2004-00006C
Project Officer: William Long
Period: February 2004 to February 2009
Funding: $75,563,890.00
Principal Investigator: Richard Apodaca
Award: Contract
Awardee: Westat Corporation
1650 Research Blvd.
Rockville, MD 20850-3129

Status: While this contract has ended, the MCBS continues to collect and distribute data under a newly awarded contract (HHSM-500-2009-00011C).

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

- determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services;
- develop reliable and current information on the use and cost of services not covered by Medicare (e.g., long-term care);
- ascertain all types of health-insurance coverage and relate coverage to sources of payment; and
- monitor the financial effects of changes in the Medicare Program.

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

Medicare 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 55th round of interviewing. To date, public use data files are available for 1991 through 2007.

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 September 2011
Funding: $799,870.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The project is underway and is studying various evaluation issues.

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 identfy those responsible for higher care costs, and then use financial incentives to change this behavior. In light of the continuing policy debate,

and to test the application of these concepts in Medicare, CMS desired a contractor to continue the work performed under the Episodic Grouper Evaluation contract. ■

Medicare Lifestyle Modification Program Demonstration: Quality Monitoring and Review

Project No: 500-02-0012
Project Officer: Kathleen Connors de laguna
Period: July 1999 to April 2009
Funding: $1,886,912.00
Principal Investigator: Roxanne Rodgers
Mike Hadad
Award: Task Order (ADP Support)
Awardee: Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, MD 21601-7098

Status: At the end of the treatment period there were 13 sites offering the Dr. Dean Ornish Program and 6 sites offering the Cardiac Wellness Expanded Program. The Schneider Institute for Health Policy, Brandeis University is completing work on the independent evaluation of the demonstration. The final evaluation report includes a comparison of clinical outcomes and assesses the quality of care delivery and patient satisfaction under the demonstration, as well as potential savings of lifestyle modification treatment services to the Medicare program. The project is now complete.

Description: The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999 to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Sites who participated in the demonstration were licensed to provide one of two nationally known treatment models: The Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute, or The Cardiac Wellness Expanded Program of Dr. Herbert Benson licensed by the Mind Body Medical Institute. The demonstration sites received 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Claims processing and payment was managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. This project contracted with the Delmarva Foundation for Medical Care, Inc. to provide continuous quality monitoring of the demonstration sites to assure the health and safety of participating Medicare patients. ■

Medicare Part D Program Evaluation

Project No: HHSM-500-2005-00029I/0009
Project Officer: Aman Bhandari
Period: September 2007 to December 2010
Funding: $1,314,157.00
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 file construction, data analysis, and research is ongoing. As of October 2009 the first draft report on the Impact of Part D on A/B Costs and Utilization was being finalized. A report due at the end of 2010 will analyze the Part D event data (PDE) to look at adherence to medications for chronic conditions and a variety of other questions.

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 underway and the contractor has completed a draft report.

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 2010
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 third year. There are currently thirteen (13) 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 2010
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 fourth year. There is currently one (1) task order awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), in addition to other CMS program reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - JEN Associates, Inc.

Project No: HHSM-500-2005-00023I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
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 fourth 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 2010
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 fourth year. Currently there are seven (7) 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 2010
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 fourth year. Currently there are five (5) 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 reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - MEDSTAT

Project No: HHSM-500-2005-00026I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
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 fourth year. Currently, there are two (2) 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 responsibilties. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Research Triangle Institute

Project No: HHSM-500-2005-00029I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
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 fourth year. Currently there are twenty-one (21) task orders awarded under this contract.

Description: The MRAD/TOC Contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the 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 2010
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 fourth year. Currently there are four (4) 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 2010
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 fourth 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 reponsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - Urban Institute

Project No: HHSM-500-2005-00030I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Urban Institute
2100 M Street, NW
Washington, DC 20037

Status: This is an umbrella contract and is in it fourth 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 reponsibilities. 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 2010
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 fourth year. Currently there are seven (7) 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-500-2005-00019I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
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 fourth year. Currently there are three (3) task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, 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-500-2005-00020I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
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 fourth year. Currently there are three (3) task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation, and survey activities relating to Medicare, Medicaid, 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-500-2005-00021I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
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 fourth 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 2010
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 fourth year. Currently there are three (3) task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstartion, 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. ■

Mercy Medical Skilled Nursing Home Payment Demonstration

Project No: 95-W-00083/04
Project Officer: Juliana Tiongson
Period: January 2002 to December 2008
Funding: $ 0.00
Principal Investigator: Kathryn Parks
Award: Waiver-Only Project
Awardee: Mercy Medical
101 Villa Drive, P.O. Box 1090
Daphne, AL 36526-1090

Status: This pilot project ended December 31, 2008 and Mercy Medical was paid via the Skilled Nursing Facility Prospective Payment System (SNF PPS). The proposed new demonstration using a bundled payment methodology for post-acute care was not approved for implementation because the previous intervention was unique to Mercy Medical System and did not appear to be replicable on a national scale.

Description: This pilot study is viewed as a period of evaluation for the purpose of working toward crafting an alternative approach to financing post-acute care that features greater integration of services and episodic payment. During the demonstration period, Mercy Medical is being paid according to the payment methodology that was used during the 2-year period authorized by the Balanced Budget Refinement Act of 1999 (BBRA), i.e., a per diem payment based on historical cost. Mercy Medical developed a proposal for a 5-year demonstration to test an alternative approach to financing post-acute care that featured increased integration of services and a bundled payment for select diagnoses. ■

Miami Jewish Home and Hospital Palliative Care Learning Services

Project No: 1C0CMS030450/01
Project Officer: Dennis Nugent
Period: August 2009 to January 2011
Funding: $214,000.00
Principal Investigator: Karen Bradley
Award: Grant
Awardee: Miami Jewish Home and Hospital for the Aged, Inc.
5200 NE 2nd Avenue
Miami, FL 33137

Status: The project staff has submitted the first quarterly report which summarizes their planning and preparation for the program's initial lecture.

Description: The objective of this program is to educate the health care community on what constitutes palliative care, how it can improve patient and family satisfaction, and to support the Centers for Medicare and Medicaid Services' mission as it relates to health care reform being implemented by the Obama administration. 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 focus will be on health care providers serving the Miami-Dade community. ■

Michigan Family Planning

Project No: 11-W-00215/05
Project Officer: Juliana Sharp
Period: March 2006 to March 2011
Funding: $ 0.00
Principal Investigator: Paul Reinhart
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 16, 2009, 42,106 individuals received family planning services through the demonstration.

Description: This demonstration covers family planning services for women ages 19 through 44, who are not otherwise eligible for Medicaid, Michigan's Health Insurance Flexibility and Accountability (HIFA) Waiver, or other coverage that provides family planning services, and who have family income at or below 185% Federal Poverty Level (FPL). ■

Michigan Health Insurance Flexibility and Accountability (HIFA) Waiver

Project No: 21-W-00017-05
Project Officer: Susan Gratzer
Period: January 2004 to December 2009
Funding: $ 0.00
Principal Investigator: Stephen Fitton
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: The demonstration ended December 31, 2009. Starting Janurary 1, 2010, the population covered by this demonstration began receiving coverage for the same benefit through a new Medicaid demonstration, Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver, 11-W00245/5). As of December 31, 2009, 73,700 adults were enrolled in this new demonstration.

Description: This demonstration allows Michigan to use unspent CHIP funds to expand benefits to childless adults ages 19-64 with incomes at or below 35% Federal Poverty Level (FPL), who are not otherwise eligible for Medicaid. ■

Minimum Data Set Technical Support Contract

Project No: 500-00-0032/0015
Project Officer: Martin Rice
Period: September 2005 to September 2009
Funding: $4,554,875.00
Principal Investigator: Terry Moore
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The period of performance was extended and the optional phase 3 was deleted. The statement of work had been scaled down because requirements had been changed. The project ended in September of 2009.

Description: The Minimum Data Set Technical Support Contract, formerly known as The Data Assessment and Verification Contractor (DAVE 2), supports the CMS's efforts in providing an ongoing centralized data surveillance process to assess the accuracy and reliability of the data particular to the health care provided by nursing facilities for these services. The findings will produce evidence for further actions at national, regional, and state levels in addressing concerns in the areas of program integrity, beneficiary health and safety, and quality improvement. ■

Minnesota 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: As of December 31, 2009, 18,897 individuals received family planning services through 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% Federal Poverty Level (FPL). ■

Minnesota Prepaid Medical Assistance Project Plus

Project No: 11-W-00039/05
Project Officer: Wanda Pigatt-canty
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: Starting February 1, 2009, parents of Medicaid and CHIP eligible children with incomes between 100% and 200% of Federal Poverty Level (FPL) who had received CHIP coverage through the MinnesotaCare Demonstration (21W-00004/5), began receiving identical coverage under the PMAP+ demonstration. On September 30, 2009, the state submitted several amendment requests related to rebasing of the budget neutrality agreement, expanding coverage to nonpregnant childless adults, and a number of changes to simplify administration of the MinnesotaCare Program. CMS is reviewing these amendment requests.

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, infants, and children with an income of up to 275% of the FPL, and parents/caretaker relatives with income up to 275% Federal Poverty Level (FPL) or $50,000 and with assets up to $20,000. MinnesotaCare pregnant women, infants, and children receive the full Medicaid benefits whereas parents and caretaker relatives receive a reduced Medicaid benefit. All of the beneficiaries that are enrolled in MinnesotaCare are required to pay premiums on a sliding scale based upon income. In addition, co-payments are required for certain services. ■

MinnesotaCare

Project No: 21-W-00004/05
Project Officer: Susan Gratzer
Period: April 2001 to January 2009
Funding: $ 0.00
Principal Investigator: Ann Berg
Award: Waiver-Only Project
Awardee: Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Status: This demonstration ended January 1, 2009, and coverage for this population was incorporated into the PMAP+ Demonstration (11-W-00039/5).

Description: The MinnesotaCare Demonstration extends coverage to parents and relative caretakers of Medicaid/CHIP children with gross income between 100-200% Federal Poverty Level (FPL) already covered under the Medicaid PMAP+ demonstration. ■

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: Currently, there are 54,776 individuals who have received family planning services through the demonstration.

Description: This demonstration provides coverage for family planning services to women with income at or below 185% of the Federal Poverty Level (FPL). ■

Missouri Family Planning

Project No: 11-W-00236/07
Project Officer: Juliana Sharp
Period: October 2007 to September 2010
Funding: $ 0.00
Principal Investigator: Karen Lewis
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: As of September 30, 2009, 30,434 individuals received family planning services through the demonstration. In December 3, 2009, the demonstration was amended to add colposcopy to the list of approved procedure codes.

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. ■

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 September 2010
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. ■

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: This project was approved for a 6 month no-cost extension until 06/30/2010.

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: 110CMS030458/01
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 is a new research award 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 prescripton 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 frequences 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-adhernece to medications and to facilitate better communication between patients and their health care providers. ■

National Evaluation of the Demonstration to Improve the Direct Service Community Workforce

Project No: 500-00-0048/0001
Project Officer: Kathryn King
Period: September 2005 to May 2009
Funding: $973,989.00
Principal Investigator: John Engberg
Award: Task Order (RADSTO)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The contractor distributed three surveys and compiled information from all returned surveys. Site visits to all 10 grantees are complete and information has been analyzed. The draft outline of the final report was approved. A Revised Statement of Work entitled, "Funds for Evaluating the Oklahoma DSW Demonstration Site" and the Contractor's Technical Proposal, were made a part of this task order. The final report was delayed because the contractor discovered two concerns with the data as the analysis was being completed. The project is complete and the final report was delivered.

Description: The purpose of this Task Order is to evaluate the impact of the 10 grants awarded by the Centers for Medicare and Medicaid Services (CMS) under the "Demonstration to Improve the Direct Service Community Workforce." These grants were awarded to test the effectiveness of the various interventions to improve the recruitment and retention of direct service workers. ■

Nevada Health Insurance Flexibility and Accountability (HIFA) Waiver Demonstration

Project No: 21-W-00053/09
Project Officer: Maurice Gagnon
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 December 31, 2009, 729 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 The Children's Health Insurance Program (CHIP) for Families and Pregnant Women

Project No: 11-W-00164/02 and 21-W-00003/02-01
Project Officer: Kathy Cuneo
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 CHIP children with family incomes up to and including 200% Federal Poverty Level (FPL) and to pregnant women who are uninsured and not covered by Medicaid, with family incomes above 185% FPL and up to and including 200% FPL. ■

New Mexico Family Planning Expansion

Project No: 11-W-00111/06
Project Officer: Thomas Hennessy
Period: May 1997 to December 2010
Funding: $ 0.00
Principal Investigator: Carol Ingram
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 December 31, 2009, 26,777 individuals received family planning services through the demonstration.

Description: This demonstration provides family planning services to uninsured women of childbearing age (18-50) who are not otherwise eligible for Medicaid, CHIP, Medicare, or New Mexico's Health Insurance Flexibility and Accountability (HIFA) Waiver amendment demonstration and who have family income at or below 185% Federal Poverty Level (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: Carol Ingram
Award: Waiver-Only Project
Awardee: Department of Human Services, Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

Status: The state imposed a waiting list effective November 2, 2009. 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 for them, 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 Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). As of December 31, 2009, there were 17,507 parents enrolled in this demonstration.

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

New Mexico Title XXI Children's Health Insurance Program (CHIP)

Project No: 11-W-00124/06
Project Officer: Andrea Casart
Period: January 1999 to December 2010
Funding: $ 0.00
Principal Investigator: Carol Ingram
Award: Waiver-Only Project
Awardee: Department of Human Services, Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

Status: As of December 31, 2009, 16,159 children participated in this demonstration.

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% Federal Poverty Level (FPL) up to, but not including, 235% FPL. ■

New York Partnership Plan

Project No: 11-W-00114/02
Project Officer: Camille Dobson
Period: July 1997 to March 2010
Funding: $ 0.00
Principal Investigator: Donna Frescatore
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Room 1466, Corning Tower Building
Albany, NY 12237

Status: New York submitted a formal extension application on March 31, 2009. The extension application incorporated pending amendment requests for 12-month continuous eligibility and mandatory managed care enrollment for recipients living with HIV, as well as requests for additional FHPlus program flexibility. Although negotiations continue on the larger demonstration extension, these programmatic amendments were approved in January, 2010.

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 had 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 Supplemental Security Income (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 September 2010
Funding: $ 0.00
Principal Investigator: Tara Larson
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: As of December 31, 2009, 56,587 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 2011
Funding: $2,605,000.00
Principal Investigator: Alan White
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The demonstration began July 1, 2009 in 3 states: Arizona, New York, and Wisconsin. The following number of nursing homes are participating in the demonstration: Arizona has 41 participating, New York has 79 participating, and Wisconsin has 62 participating. CMS is collecting payroll data from participants each quarter to assess performance in the staffing domain, and will assess the other 3 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: 1H0CMS030457/01
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

Status: This is a new grant award under the Hispanic Health Services Reserch 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 thier 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; and 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: Thomas Hennessy
Period: November 2004 to March 2010
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, Oklahom requested as 3 year extension. As of December 31, 2009, 23,073 individuals received family planning services through the demonstration.

Description: The demonstration allows Oklahoma 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. Eligibility for family planning services are also extended to 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: On December 30, 2009, the demonstration was renewed for a three-year period ending December 31, 2012. As part of the January 2010 renewal, the Health Access Network pilot program was approved and eligibility under Employer Sponsored Insurance (ESI) was expanded to 250% Federal Poverty Level (FPL).

Description: The SoonerCare demonstration provides services to Temporary Assistance for Needy Families (TANF) related populations and the aged and disabled with some exceptions. In 2005, Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) related 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, to expand the size of employers who can participate in the Employer Sponsored Insurance (ESI) program, and to 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: This project was extended at no additional cost until 12/31/2010.

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. ■

Oregon Family Planning

Project No: 11-W-00142/00
Project Officer: Juliana Sharp
Period: October 1998 to March 2010
Funding: $ 0.00
Principal Investigator: Jim Edge
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: As of December 31, 2009, 61,972 individuals received family planning services through this demonstration. On May 1, 2009, Oregon requested a 3-year extension, which is currently under review.

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, CHIP, or Medicare, and who have family income at or below 185% Federal Poverty Level (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 2010
Funding: $ 0.00
Principal Investigator: Jim Edge
Award: Waiver-Only Project
Awardee: Oregon, Department of Human Services
500 Summer St, NE - E10
Salem, OR 97301-1076

Status: On December 23, 2009, the State received a demonstration amendment that allows expansion of health care coverage through the Family Health Insurance Assistance Program (FHIAP) to uninsured children, parents, and childless adults with family incomes above 185% through 200% Federal Poverty Level (FPL). Effective January 1, 2010, as part of the State's Healthy Kids Initiative, a second expansion of eligibility will include CHIP coverage for children with family income between 200% and 300% FPL. These higher income children may enroll either in subsidized private insurance coverage through FHIAP, or a new private insurance program developed by the State called Healthy KidsConnect.

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. The sources are 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% Federal Poverty Level (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% of 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. ■

Patient Advocate Foundation

Project No: 1C0CMS030440/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $190,000.00
Principal Investigator: Beth Darnley
Award: Grant
Awardee: Patient Advocate Foundation
700 Thimble Shoals Blvd., Suite 200
Newport News, VA 23606

Status: The project is underway.

Description: 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. ■

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 September 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.

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 6 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: Using information suppled by LifeMasters, the contractor developed monthly rates for the project. The contractor is providing Medicare claims information on the beneficiaries that are enrolled in the disease management treatment group on a quarterly basis. The contrator also provides summary information relating to Medicare claims for the control group. The contractor monitors the Medicare claims for both treatment and control groups and on a quarterly basis provides a detailed analysis to CMS and the project for monitoring their progress in maintaining budget neutrality. Previously under this contract, the contractor provided the same analysis and monitoring support for the Benefits Improvement and Protection Act (BIPA) Disease Management Demonstration, which ended in 2006.

Description: The purpose of this task order is to provide support to the Centers for Medicare & Medicaid Services (CMS) in implementing and monitoring 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: $1,777,854.00
Principal Investigator: John Wilkin
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

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

Description: This 3-year demonstration was mandated under Section 649 of the MMA to promote the use of health information technology and improve the quality of care for beneficiaries. Doctors in small to medium sized practices who meet clinical performance measure standards will receive a bonus payment for managing the care of eligible Medicare beneficiaries. The demonstration 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 December 31, 2009, 13,160 women were enrolled in the demonstration.

Description: The Pennsylvania Family Planning demonstration offers eligibility for family planning services to women from age 18 to 44 who have family income below 185% Federal Poverty Level (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
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.

Description: The performance-monitoring task order provides the means to monitor Medicare Health Support operations and collect data needed to track clinical performance of participating disease managment organizations and utilization of health resources by the intervention and control groups during Phase I of this pilot project. The monitoring process is dependent upon collaboration among several contractors, CMS, and the Medicare Support Organizations (MHSOs), to ensure the specification, collection, storage, and reporting of accurate clinical data for Medicare beneficiaries in the intervention and control groups (particularly intervention group beneficiaries 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's (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) for 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 have been developed, tested, and are being implemented via an online application. Data collection is active on all project sites. Collection of data will continue through the end of 2009 and has been expanded to include additional long-term care hospital and acute hospital sites.

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

Status: The contract was modified to increase the level of effort under Tasks 5 and 15. The contractor's technical proposal, entitled "Post Acute Care: Patient Assessment Instrument Development," was incorporated by reference and made a part of the task order. Funding was increased in the past year by $3,498,889. The contract's period of performance was also extended by 4 months. As of 1/20/2010, 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. Research Triangle Institute (RTI) 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. ■

Practice Expense Methodology

Project No: HHSM-500-2004-00054C
Project Officer: Kenneth Marsalek
Period: September 2004 to September 2009
Funding: $385,626.00
Principal Investigator: Allen Dobson
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Status: CMS is no longer accepting supplementing survey data. The AMA is planning a survey of physician practices. CMS staff and the contractor met with AMA staff to discuss various approaches to surveying non-physician practitioners to obtain practice expense data. The contractor's technical proposal was incorporated and made a part of this contract. The Period of Performance was extended through September of 2009. This project then ended September 30, 2009.

Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule. Until January 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. In 1989, Congress established a fee schedule for the payment of physicians' services. Under the formula set forth in the law, the payment amount for each service is the product of three factors: a nationally uniform relative value; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor that converts the relative value units (RVUs) into payment amounts for services. The RVUs for each service reflect the resources involved in furnishing the three components of a physician's service: physician work (i.e., a physician's own time and effort); practice expenses net of malpractice expenses; and malpractice insurance expenses. The original practice expense RVUs were derived from 1991 historical allowed charges. A common criticism was that for many items these RVUs were not resource-based because they were not directly based on the physician's resource inputs. CMS was required to implement a system of resource-based practice expense relative value units (PERVUs) for all physicians' services by 1998. The Balanced Budget

Act of 1997 (BBA) made a number of changes to the system for determining PERVUs, including delay of initial implementation until 1999 and provision for a 4-year transition. To obtain practice expense data at the procedure code level, CMS convened Clinical Practice Expert Panels (CPEPs). The CPEPs provided the direct inputs of physician services, i.e., the amount of clinical and administrative staff time associated with a specific procedure and medical equipment and medical supplies associated with a specific procedure. In June 1997, we published a proposed rule for implementing resource-based practice expense payments. The methodology incorporated elements of the CPEP process to develop the direct expense portion of the PERVU. The indirect expense portion of the PERVU was based on an allocation formula. In addition to delaying the implementation of resource-based practice expense payments until January 1, 1999, the BBA phased in the new payments over a 4-year transition period. In developing new practice expense RVUs, we were required to utilize, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be linked to specific procedures; use actual data on equipment utilization and other key assumptions; consult with organizations representing physicians regarding methodology and data to be used; and develop a refinement process to be used during each of the 4 years of the transition period. In June 1998, we proposed a methodology for computing resource-based practice expense RVUs that used the two significant sources of actual practice expense data we had available: CPEP data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. This methodology was based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physicians' services across specialties. It then allocated these aggregate specialty practice costs to specific procedures and, thus, could be seen as a "top-down" approach. We used actual practice expense data by specialty to create six cost pools: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools: 1) we used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category; (2) we determined the total number of physician hours, by specialty, spent treating Medicare patients; and (3) we then calculated the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours. For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group. For group one, which included clinical labor, medical supplies, and medical equipment, we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively. For group two, which included administrative labor, office expenses, and all other expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs were used to allocate the cost pools. For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients. The BBA also required that the Secretary develop a refinement process to be used during each of the 4 years of the period. In the 1998 notice, we finalized the proposed methodology but stated that the PERVUs would be interim throughout the transition period. Additionally, we envisioned a two-part refinement process: the AMA had established a Practice Expense Review Committee to review detailed, Current Procedural Terminology code level input data; and CMS would request contractual support for assistance on methodology issues. This project provided that contractual support. ■

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

Project No:	HHSM-500-2006-00006I/HHSM-500-T00001
Project Officer:	Angela Taube
Period:	September 2009 to September 2010
Funding:	$268,757.00
Principal Investigator:	Edward Kako
Award:	Task Order (XRAD)
Awardee:	Acumen, LLC 500 Airport Blvd. Suite 365 Burlingame, CA 94010

Status: This contract is currently active.

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 physicial 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. ■

Premier Hospital Quality Incentive Demonstration

Project No: 500-00-0015/0002
Project Officer: Linda Radey
Period: September 2004 to December 2008
Funding: $999,970.00
Principal Investigator: Stephan Kennedy, Ph.D.
Kevin Coleman
Cheryl Damberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project has concluded. A follow-up evaluation of all six years of the demonstration is completed.

Description: This project evaluated the impact of the Premier Hospital Quality Incentive (HQI) Demonstration on the quality and Medicare reimbursments for five prevalent inpatient diagnoses. Under the demonstration, CMS rewarded top-performing hospitals in each year of the demonstration. Based upon an absolute level of quality that was established after the first year, CMS penalized hospitals in the third year of the demonstration that performed below that established level of quality. ■

Premier Hospital Quality Incentive Demonstration (HQID)

Project No: 95-W-00103/04
Project Officer: Katharine Pirotte
Period: October 2003 to September 2009
Funding: $ 0.00
Principal Investigator: Diana Jackson
Award: Waiver-Only Project
Awardee: Premier Healthcare Informatics
2320 Cascade Pointe Boulevard
Charlotte, NC 28208

Status: An extension of the HQID was approved from fiscal year 2007 through fiscal year 2009. The most notable changes in the extended demonstration were in the payment methodology, which included incentives for quality improvement as well as for achieving high quality. The objectives were to test new payment models, ways to measure quality, and methods to support designing CMS value-based purchasing models. For the extension, CMS had budgeted $12 million per year for demonstration incentives. CMS awarded incentive payments totalling $12 million in year 4 to 225 hospitals for top performance, top improvements, and overall attainment in the five clinical areas. The operation of the demonstration ended, September 30, 2009. CMS is continuing to analyze the data and will be awarding incentive payments for years 5 and 6.

Description: The purpose of the demonstration is to determine the effectiveness of improving the quality of inpatient care for Medicare beneficiaries by awarding quality incentive payments to hospitals for high quality in several clinical areas, and by reporting extensive quality data on the CMS Web site. The demonstration involves a CMS partnership with Premier, Inc., a nationwide organization of not-for-profit hospitals that operates a quality measurement system. The demonstration began on October 1, 2003 with 278 Premier hospitals. The Medicare payments of the incentive bonuses for year 1 was about $8.85 million, $8.69 million for year 2, and $7.0 million for year 3. The average composite quality score and the aggregate of all quality measures within each clinical area improved significantly since the inception of the program in all five clinical focus areas. These clinical areas are: acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacement. ■

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 granted a 12 month no-cost extension until 12/31/2010.

Description: The Prescription Assistance Program under the Gadsden Community Health Council, Inc., helps patients with a gross income of 200% of the Federal Poverty Level 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. ■

Prescription Drug Coverage in Medicaid: Using Medicaid Claims Data to Develop Prescription Drug Monitoring and Analysis

Project No: 500-00-0047/0002
Project Officer: David Baugh
Period: September 2002 to May 2009
Funding: $1,172,286.00
Principal Investigator: Jim Verdier
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has prepared a full set of data tables in the form of a statistical compendium, using MAX data for the 50 States and Washington, D.C. The tables provide detailed information on prescription drug utilization and spending for three major populations: all Medicaid, dual enrollees, and Medicaid nursing facility residents. The contractor has also produced a Chartbook "Medicaid Pharmacy Benefit Use and Reimbursement." The Statistical Compendium is available for 1999 and 2001-2005; and Chartbooks are available for 1999, 2001-2003 on the CMS Web site at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp.

This contract has also produced research papers. One paper has been published and others are in review. The publication reference is: Bagchi, A., Esposito, D., and Verdier, J.: Prescription Drug Use and Expenditures Among Dually Eligible Beneficiaries. Health Care Financing Review, Summer 2007, Vol. 28, No. 4, pages 43-56.

Description: Rapid growth in Medicaid prescription drug expenditures, serious State budget problems, and the congressional debate on Medicaid prescription drug coverage have combined to draw increasing attention to prescription drug use in Medicaid. The new Medicaid Analytic eXtract (MAX) database for 1999 provides an opportunity to develop tables, graphs, and analyses that can illuminate these prescription drug issues for Federal and State policymakers, stakeholder groups, and researchers at a level of detail not readily available to date. This contract uses the MAX data to address Medicaid and Medicare prescription drug issues. ■

Produce and Disseminate Program Statistics from Section 723 Chronic Conditions Warehouse (CCW)

Project No: HHSM-500-2006-00008I/0001
Project Officer: Chris Haffer
Period: August 2006 to August 2009
Funding: $1,096,074.00
Principal Investigator: Wendy Funk
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project is complete.

Description: The contractor was accountable for evaluating the robustness of the CCW for research purposes and creating data files and program statistics

based on the contractor's analyses of the CCW data. The analyses from the first objective created a "blue print" of the types of statistics the CCW is capable of supporting. These newly created statistics addressed emerging themes in chronic disease with a special focus on Diabetes, Alzheimers Disease and related dementias. In addition, the contractor developed Data Users Guides to facilitate the use of the Diabetes and Alzheimer's Disease analytical data sets. The incumbent established a data users group to share data findings and comment on anomalies of the data. The contractor produced a statistical report and a manuscript suitable for publication in a peer-reviewed journal using data from the Diabetes Analytical Data Set and the Alzheimer's Disease Analytical Data Set. In addition, the contractor produced a manuscript suitable for publication in a peer-reviewed journal of the Alzheimer's Disease Literature Review. The contractor conducted an evaluation of both process (i.e. the process of creating the analytical data sets from the CCW) and outcome (how usable were the data sets by the various stakeholders). The evaluation report contained well informed and reasoned recommendations – with data collected from a variety of sources – that provide insight into future improvements to both process and outcome. ■

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

Project No: 1C0CMS030444/01
Project Officer: Michael Henesch
Period: August 2009 to January 2011
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 will assume 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: The project is underway.

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 incoporated 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 1/1/10 - 12/31/10 will not be 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 2010
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 (QIS) Training And Analysis

Project No: 500-00-0052/0001
Project Officer: Karen Schoeneman
Period: July 2005 to September 2009
Funding: $3,308,154.00
Principal Investigator: Andrew Kramer
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The contract was modified to increase the level of effort, and revise the Statement of Work and Schedule of Deliverables. The period of performance was extended to September 2009. The total funding was increased by $825,000. The contractor has continued with the maintenance of a help desk and is now involved in a set

of analytic tasks to assist CMS in the design of additional features of the nursing home survey process including: 1) a new federal monitoring data system (DAR)and onsite review process (FOQIS), revisit survey, and extended survey; 2) providing DAR data reports; 3) analysis and training to federal survey personnel; 4) data threshold revamping; 5) periodic data reporting; 6) providing revisions to QIS forms and processes according to analyses performed regarding the operation of the QIS in participating States; and 7) providing expert assistance to a programming contractor that is inserting the QIS into CMS' data systems. The contract was ended on schedule and a new competitive procurement was awarded to continue this developmental effort.

Description: The Quality Indicator Survey (QIS) is a revised long-term care survey process that was developed under Centers for Medicare & Medicaid Services (CMS) oversight through a multi-year contract. The QIS was designed as a staged process for use by surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review. The QIS provides a structure for an initial review of larger samples of residents based on the Minimum Data Set (MDS), observations, interviews, and medical record reviews. Utilizing onsite automation, survey findings from the first stage are combined to provide rates on a comprehensive set of Quality of Care Indicators (QCIs) covering all resident and facility level federal regulations for nursing homes. The second stage then provides surveyors the opportunity to focus survey resources on further investigation of care areas where concerns exist. In this follow-on contract, the contractor ran a demonstration of the QIS in 5 States. Additionally, the contractor has been providing training to additional State surveyors, developing and providing a course to train State trainers, and is completing various analysis and monitoring activities, as the QIS moves to wider implementation. ■

Quality Indicator Survey Implementation and Analysis

Project No: HHSM-500-2005-00022I/HHSM-500-T0001
Project Officer: Susan Joslin
Period: September 2009 to September 2010
Funding: $959,973.00
Principal Investigator: Martha Powell
Award: Task Order (MRAD)
Awardee: University of Colorado
PO Box 2393
Denver , CO 08543

Status: The project is progressing on schedule. We expect the production QIS software will be released in June 2010.

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 tate, as funds become available to have our training contractor train additional surveyors. Simultaneously, CMS is continuing with the current contractor, the Unviersity 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 Unviersity of Colorado and the CMS data contractor. The QIS manual resides on the Unviersity of Colorado's website and is accessible at http://www.uchsc.edu/hcpr/qis_manual.php. 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: The grant is now fully funded. The Utah Medical Education Council is seeking ways to sustain its efforts once the demonstration waiver ends June 30, 2010.

Description: Since 1997, CMS has been working 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 are 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. ■

Recruitment of a Primary Care Workforce for New Hampshire

Project No: 1C0CMS030441/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $105,000.00
Principal Investigator: Stephanie Pagliuca
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: The project is underway.

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 March 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 statment of work revisions to Task 15 are necessary to ensure that eROVER is compatible with the new grouper (JAVA version) and OASIS-C. Funding has been increased and the period of performance has been extended to March 31, 2010.

Description: The eROVER is a software package that was developed for Regional Home Health Intermediarys (RHHIs) to assess the accuracy of Home Health Resource Groups (HHRG) by verifying the accuracy of the underlying Outcome and Assessmant Information Set (OASIS) data. The eROVER software allows agency OASIS responses to be electroncially 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 contract is currently being modified to increase the number of workshops/ training, the help

desk support services, and the website resources for Comparative Effectivness 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. ■

Research Data Distribution Center

Project No: 500-01-0031/0001
Project Officer: Terry Maddox
Period: June 2005 to December 2008
Funding: $3,925,469.00
Principal Investigator: Damien Marston
Kim Elmo
Award: Task Order (ADDSTO)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The period of performance was extended through December 31, 2008. Special invoice requirements pursuant to the requirements of Task 5, "Track and Report Information on Customer Orders," of the Statement of Work, required that the contractor submit monthly invoices to include: 1) a total accounting of all reimbursable charges for both private researchers and federal agencies; 2) a separate total breakout of all reimbursable charges for private researchers; 3) a separate breakout of all reimbursable charges for each of the federal agencies; and 4) a total of cumulative reimbursable charges by private researchers and each federal agency. This contract has expired.

Description: This task order will serve as a pilot test of the concept of a Centers for Medicare and Medicaid Services (CMS) data distribution center. This contractor will function as the single point of contact for public and private researchers seeking access to CMS program enrollment data, Medicare claims data, and Medicaid research files. Using the information gained from the pilot, CMS anticipates a future competitive contract to operate one or more data distribution centers on an ongoing basis. ■

Revision of Medicare Wage Index

Project No: HHSM-500-2006-00006I/0011
Project Officer: Craig Caplan
Period: February 2008 to August 2010
Funding: $688,807.00
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 to be released in a final report that has multiple parts. Final Report Part I was released in Spring 2009. Part II of the Final Report is in progress.

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, and
- 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 impelmentation 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: Marge Ware
Award: Waiver-Only Project
Awardee: Rhode Island, Division of Health Care Quality, Department of Human Services
600 New London Avenue
Cranston, RI 02920

Status: Rhode Island implemented the Global Consumer Choice Demonstration on July 1, 2009. In December 2009, amendments were approved to accommodate the transfer of coverage for uninsured pregnant women from Medicaid to Children's Health Insurance Program (CHIP). Rhode Island exercised the option to provide CHIP coverage to pregnant women using CHIP state plan option found at section 111 of Children's Health Insurance Program Reauthorization Act (CHIPRA).

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. Rhode Island'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. ■

Rhode Island RIteCare

Project No: 11-W-00004/01
Project Officer: Camille Dobson
Period: November 1993 to July 2009
Funding: $ 0.00
Principal Investigator: Marge Ware
Award: Waiver-Only Project
Awardee: Rhode Island, Division of Health Care Quality, Department of Human Services
600 New London Avenue
Cranston, RI 02920

Status: The RIteCare demonstration ended on June 30, 2009, and was replaced by the Global Consumer Choice demonstration (11-W-00242/1).

Description: The Rhode Island RIte Care demonstration is a statewide program that delivers primary and preventive health care services for all Family Independence Program families (formerly known as AFDC families) and certain low-income women and children through a fully capitated managed care delivery system. The demonstration also includes RIte Share, a premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored

insurance (ESI). Under RIte Share, Rhode Island pays all or part of an eligible family's monthly premium, based on income and family size, for an employer's Department of Human Services (DHS)-approved ESI. RIte Share provides coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments. Finally, the state provides replacement windows in the homes of lead-poisoned children enrolled in the demonstration. ■

Rural Hospice Demonstration: Quality Assurance Metrics Implementation Support

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

Status: The contract was modified to exercise option years 1, 2, and 3.

Description: The Rural Hospice demonstration has had significant lessons learned from the implementation of the quality measures. Each site has taken on a project to increase awareness of and use of hospice services to underserved populations. The quality metrics for the demonstration were developed through a collaborative process that included CMS staff, the QA contractors, and representatives of both demonstration sites. The metrics were designed to cover multiple areas of hospice operations and to be:

- patient-focused and outcome oriented;
- valid, reliable, and feasible to use in hospice settings;
- meaningful to participating hospices; and
- composed of data elements that were either currently being collected at each site, or could be collected relatively easily.

We also focused on metrics for which comparative/benchmarking data were available. The sites reported that the aggregated metrics are a sound set of core measures. The sites reported that the ability to access the measures online has 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. The data is more meaningful and useful in these formats. Both sites had identified opportunities for improvement and were taking action to improve performance. While each demonstration site developed its own project to increase awareness of hospice and use of hospice services to underserved populations, their projects were similar in the following realizations:

- recognized the need to approach groups differently based on cultural sensitivities
- goal to engage in dialogue about hospice
- need to develop rapport one-on-one
- meet at places familiar to the group
- church is an ideal setting
- as comfort level increases, engage with the hospice in other settings — note early benchmark goal
- recognized that it is a long-term project in order to see results
- cultural Sensitivities:
    - discuss hospice services, such as pain management
    - do not discuss dying; it is tantamount to giving up in these communities
    - engage the concept of family as it relates to hospice
    - hospice staff cannot be perceived as taking the place of family, since family is there to provide care
- trust must be earned
- families that have been served are their best referral sources
- word of mouth is key
- multi-prong approach is required**.** ■

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

Project No: HHSM-500-2005-00028I/0002
Project Officer: Amy Heller
Period: September 2006 to September 2010
Funding: $10,246,633.00
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 3 and to exercise Option Year 3. The total estimated cost plus fixed fee for full performance of this task order was increased by $3,151,860, from $7,094,773 to $10,246,633. The period of performance for this task order was extended to September 28, 2010.

Description: This task order will implement sample design, data analysis, and reporting for the Medicare Consumer Assessments of Health Providers and Systems (CAHPS) Surveys among samples of persons with Medicare and Medicare Fee-For-Service (FFS) in Medicare Advantage (MA) plans. ■

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 is now fully funded.

Description: This task order will further evaluate the statistical significance and strength of the relationship between the Health Insurance Flexibility and Accountability (HIFA) initiative and the number and rate of uninsured for health care in states that implement HIFA demonstrations. ■

SHIP Measurement and Reporting System

Project No: HHSM-500-2005-00019I/0002
Project Officer: Patricia Gongloff
Period: September 2008 to September 2009
Funding: $956,701.00
Principal Investigator: Ben Smith
Award: Task Order (XRAD)
Awardee: American Institute for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007-3835

Status: The project is complete.

Description: As demands, expectations, and funding for the State Health Insurance Assistance Program (SHIP) increase under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), CMS requires an improved performance measurement system to manage the program effectively. Goals for the SHIP network include: 1) Increased access to information on Medicare covered services including preventive benefits; 2) Personalized counseling services; and 3) Partnership development and assistance in accessing benefits, including enrollment assistance provided to beneficiaries in the Medicare Prescription Drug Coverage Program The purpose of this task order is to further improve and provide maintenance support to the current SHIP National Performance Reporting system and performance measurement process and implement performance targets established by CMS. Therefore, CMS will be able to determine whether SHIP programs meet the goals set forth by CMS, the enabling legislation (Section 4360 of OBRA 1990:Public Law 101-508), the outreach and education requirements of the Balanced Budget Act of 1997 (BBA), and MMA. The contractor will generate SHIP performance reports and other ad hoc reports that are based on data gathered for the most recent reporting periods, provide technical assistance to SHIP programs on their data reporting systems, analyze data and the performance of SHIPs relative to the SHIP performance targets, and assess the need for revised or different performance targets and data requried to support those targets. ■

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: This project was extended at no additional cost until 6/30/2010.

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 March 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 Progress Report and Financial Report are due to CMS in Janurary 2010.

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 check ups, teeth cleaning, extracions, 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 2009
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: The project is continuing with its implementation efforts. These efforts include: 1) developing and executing the required partnerships, and 2) obtaining data from each of the participating practices. The principal investigator has requested a one year extension to complete the project.

Description: The goal of this study is to improve the effectiveness and safety of drug therapies required by Medicare beneficiaries through the provision of a structured, documented chronic disease case management service. This service will be delivered to Medicare-eligible beneficiaries who are referred by their collaborating physicians, in communities with a high population of Medicare recipients. The objective of this study is 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 will be a retrospective analysis of Medicare claims data for beneficiaries who did receive CPP services. The claims data for this population could be compared to beneficiaries who did not receive CPP services. The following parameters will be assessed: 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 2010
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.

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 2010
Funding: $148,304.00
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 5-year contract ended September 29, 2009. A new 3-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: $425,000.00
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. 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 will provide a critical ongoing consultative role in the implementation and operation of the EHR demonnstration 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 to CMS 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 has implemented training for direct care staff by consultants and introduced appropriate training materials to improve staff performance and job satisfaction, resident and family satisfaction, teamwork among staff, and to reduce trunover rates. CMS has granted a 5 month no-cost extension through 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 susequent year grants have been completed and are on the CMS website. The Strategic Plan Template and initial onsite visits for the Systems Transformation (ST) Grantees have been completed. All tasks and activities on are time. Finalizations of the Strategic Plan web format and review and approval of ST Grantees Strategic Plans are completed. The web-based RCSC Grant Program management reports are in development. The contract was recently modified to: 1) increase the level of effort for Task 7; 2) modify Task 4; and 3) revise the Statement of Work and the Schedule of Deliverables.

Description: The purpose of this task order is to: examine the systems and impacts of the Fiscal Year 2005 Real Choice Systems Change (RCSC) Grants; provide limited technical assistance (TA) to 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 regarding Diabetes and High Blood Pressure

Project No: 11OCMS030310/02
Project Officer: Richard Bragg
Period: September 2008 to September 2010
Funding: $225,000.00
Principal Investigator: Elizabeth Bertera
Award: Grant
Awardee: Howard University OSP-Research Administration
576 W Street NW
Washington, DC 20059

Status: This grant is in its second year (continuation) under the Historically Black Colleges and Universities (HBCU) Health Services Research Grant.

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 September 2010
Funding: $737,738.00
Principal Investigator: Henry Goldberg
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: CMS plans to exercise Phase II of this contract to provide services for analysis of quality performance and savings calculations.

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. Phase I will last through December 2009 and Phase II, if exercised, will extend the task order to September 30, 2010. ■

Technical Oversight and Support

Project No: HHSM-500-2006-00005I/0007
Project Officer: Lawrence Caton
Period: September 2008 to September 2011
Funding: $295,851.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The contract is in process and has been extended to September of 2011.

Description: CMS is responsible for implementing and monitoring demonstration projects undertaken across the United States. The purpose of this task order is to provide CMS the support to assist in Medicare program development and monitoring of industry partners who participate in these demonstrations. There are a number of demonstrations that require budget neutrality which requires expert monitoring and oversight by the contractor throughout the demonstration. ■

TennCare II

Project No: 11-W-00151/04
Project Officer: Kelly Heilman
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: On July 22, 2009, Tennessee received approval for Amendment #7, which authorized the TennCare CHOICES program. Tennessee plans to begin a phased implementation of CHOICES in March 2010. On December 15, 2009, the state received approval for a 3-year extension of the demonstration, through June 30, 2013, under provisions of section 1115(e).

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 (DSH) funds to extend Medicaid eligibility to selected low-income uninsured populations. All Medicaid state plan eligibles are enrolled in managed care under TennCare II, except those whose only Medicaid benefits consist of Medicare premium payments. State plan populations receive the TennCare Medicaid benefit package, while expansion populations receive TennCare Standard, with some state plan benefits omitted. In 2005, 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 cover non-pregnant medically needy adults as a demonstration population, with enrollment capped at 105,000. In early

2010, Tennessee is expected to implement the TennCare CHOICES program, which will provide coverage for nursing facility and home and community based services for aged and disabled individuals through the same capitated managed care plans that provide general medical coverage. ■

Texas Disaster Relief

Project No: 11-W-00241/06 and 21-W-00061/06
Project Officer: Juliana Sharp
Period: October 2008 to April 2009
Funding: $ 0.00
Principal Investigator: Chris Taylor
Award: Waiver-Only Project
Awardee: Texas, Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247

Status: This demonstration ended April 30, 2009.

Description: The Texas Disaster Relief demonstration was granted in recognition of the public health emergency in Texas caused by Hurricane Ike in September 2008. The demonstration relieved Texas of some requirements related to eligibility redeterminations. Texas was permitted to continue an individual's eligibility under Texas's title XIX and XXI programs in 29 Federal Emergency Management Agency designated disaster counties for individuals whose redeterminations were due from October 1 through November 30, 2008. Eligibility could continue until January 31, 2009, unless information was received by the state Medicaid agency or the Texas Health and Human Services Commission earlier than this date, indicating that a redetermination was warranted. ■

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 November 30, 2009, 98,140 individuals received family planning services through this demonstration.

Description: This demonstration provides family planning services for uninsured women aged 19 through 44 who are not otherwise eligible for Medicaid, CHIP, Medicare, or any other creditable health care coverage, and who have family income at or below 200% Federal Poverty Level (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 is due to close in March of 2010, after receipt of final progress and financial reports.

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 Expendtiure Projections

Project No: HHSM-500-2006-00006I/0015
Project Officer: Todd Caldis
Period: September 2008 to March 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 paper is in final review. The contractor is also working on an applied paper intended to make theoretical conclusions from the project accessible to a wider policy audience.

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; and 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. The third phase of pre-implementaiton analysis has begun with the development of the RUG-34, 44 and 53 Medicaid Groupers and will include the completion of the STRIVE Final Report.

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, 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, develop RUG-34, 44 and 53 Medicaid Groupers for RUG-IV, develop training materials for the new Medicaid Grouper, and provide a national "Train the Trainer" conference in Baltimore, MD. ■

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 2010
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. ■

Trends in Out-of-Pocket Health Care Costs Among Elderly Community Dwelling Medicare Beneficiaries

Project No: CMS-ORDI-2008-0002
Project Officer: Gerald Riley
Period: February 2007 to October 2008
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 published in the October 2008 issue of American Journal of Managed Care. Source: Riley, G.F. Trends in Out-of-Pocket Health Care Costs Among Elderly Community Dwelling Medicare Beneficiaries. American Journal of Managed Care, vol. 14, no. 10, pp. 692-696, October 2008. Medicare Current Beneficiary Survey data were analyzed for community dwelling beneficiaries aged 65 or over, between 1992 and 2004. The primary focus of the analysis was out-of-pocket health care costs and out-of-pocket costs as a percent of income. Descriptive statistics are presented for four years: 1992, 1996, 2000, and 2004. The results showed that inflation-adjusted median out-of-pocket costs was relatively stable between 1992 and 2000, then rose by 22 percent between 2000 and 2004. Costs as a percent of income declined between 1992 and 1996, but increased from 12.6 percent in 2000 to 15.5 percent in 2004. Out-of-pocket costs increased fastest at the upper percentiles of the distribution. High out-of-pocket costs tended to persist from year to year, exacerbating the financial burden for some beneficiaries. In conclusion, following a period of declining burden between 1992 and 1996, out-of-pocket health care costs rose significantly between 2000 and 2004, increasing the financial burden for many elderly Medicare beneficiaries. These data provide a baseline for evaluating the impact of Medicare reform proposals that may impact beneficiary spending.

Description: Medicare Current Beneficiary Survey data were used to examine trends in out-of-pocket health care costs incurred by elderly community dwelling Medicare beneficiaries between 1992 and 2004. The objective of this project was to describe trends in out-of-pocket health care costs, including insurance premiums, for elderly Medicare beneficiaries living in the community. Specific questions include: 1) How much have out-of-pocket costs increased absolutely and relative to income?; 2) Has the distribution of out-of-pocket costs changed over time?; 3) How do costs vary by beneficiary characteristics such as income and health status?; and 4) To what extent do high out-of-pocket costs persist from year to year? ■

Trends in Out-of-Pocket Health Care Costs for Community Dwelling Medicare Beneficiaries

Project No: CMS-06-110106
Project Officer: Gerald Riley
Period: November 2006 to October 2008
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 was published in "The American Journal of Managed Care" in October of 2008. The project is now complete.

Description: Many Medicare reform proposals call for more beneficiary contributions to the cost of their health care. This study examines recent trends in beneficiary out-of-pocket health care costs, using data from the Medicare Current Beneficiary Survey (MCBS) Cost and Use Files for 1992-2004. The study is limited to the community dwelling population. All out-of-pocket health care costs are included, not just those associated with Medicare-covered services, in order to get a complete picture of the financial burden of health care on beneficiaries. Several questions are addressed: 1) How much have out-of-pocket costs increased in relation to total health care costs and to income?; 2) Has the distribution of out-of-pocket costs changed over time?; 3) Have the major components of out-of-pocket costs changed and are they different for the highest cost beneficiaries?; 4) How do costs vary by type of supplemental insurance?; and 5) To what extent do high out-of-pocket costs persist from year to year? ■

Uncompensated Care for Vulnerable Populations

Project No: 1C0CMS030443/01
Project Officer: Pamela Pope
Period: August 2009 to January 2011
Funding: $190,000.00
Principal Investigator: Lori Real
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: The project is underway.

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. ■

Utah Primary Care Network

Project No: 11-W-00145/08 and 21-W-00054/08
Project Officer: Kelly Heilman
Period: February 2002 to June 2010
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 December 18, 2009, the demonstration was amended to expand the premium assistance component of the demonstration to include subsidies for the purchase or maintenance of COBRA continuation coverage. Families that qualify for Federal assistance with COBRA premiums, made available by the American Recovery and Reinvestment Act of 2009 (ARRA), may receive the ARRA subsidy and the assistance provided under this demonstration. The State has informed CMS of its intention to seek a 3-year extension for the demonstration under provisions of section 1115(f) of the Act.

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 Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. Through the demonstration, up to 25,000 uninsured adults age 19 and older with incomes up to 150% Federal Poverty Level (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 Utah'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: Thomas Hennessy
Period: September 2005 to September 2010
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: As of September 30, 2009, 149,444 individuals were enrolled in the Global Commitment to Health demonstration, including 30,864 enrolled in the pharmacy benefit program and approximately 7,000 receiving premium assistance or enrolled in the Catamount Health Program. On December 23, 2009, an amendment was approved expanding coverage to provide premium assistance benefits to individuals with incomes of up to 300% Federal Poverty Level (FPL). In addition, eligibility for the pharmacy benefit was extended from 175% to 225% of FPL for low income Medicare beneficiaries only, and the required period of uninsurance for childless adults and for parents with incomes above 150% FPL was changed from 12 months to 6 months.

Description: Through the Vermont Global Commitment to Health demonstration, the Office of Vermont Health Access (OVHA) operates as a public managed care entity. OVHA receives a monthly per member-per month (PMPM) payment 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 a five-year aggregate budget neutrality expenditure limit of $4.7 billion. ■

Virginia Family Access to Medical Insurance Security (FAMIS) MOMS and FAMIS Select

Project No: 21-W-00058/03
Project Officer: Andrea Casart
Period: June 2005 to June 2010
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: As of December 31, 2009, 3,572 pregnant women received CHIP coverage under this demonstration, and 452 children exercised the option to receive premium assistance for employer-sponsored insurance in lieu of the separate CHIP benefit. The state has requested a 3-year extension.

Description: FAMIS MOMS provides full Medicaid coverage to pregnant women with incomes above 133% Federal Poverty Level (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. ■

Virginia Family Planning

Project No: 11-W-00152/03
Project Officer: Thomas Hennessy
Period: July 2002 to September 2010
Funding: $ 0.00
Principal Investigator: Patrick Finnerty
Award: Waiver-Only Project
Awardee: Virginia, Department of Medical Assistance Services
600 East Broad St, Suite 1300
Richmond, VA 23219

Status: On December 20, 2009, Virginia requested an amendment to revise the list of approved procedure codes, which is pending review. As of January 4, 2010, 4,832 individuals received coverage for family planning services through this 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% Federal Poverty Level (FPL). ■

Waiver Management System Database and Grant On-Line Management System

Project No: 500-00-0021/0004
Project Officer: Herbert Thomas
Period: August 2005 to December 2008
Funding: $4,079,117.00
Principal Investigator: Majorie Hatzman
Award: Task Order (RADSTO)
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: The contract ended on December 14, 2008, but tasks to transition the WMS to CMS facility has been included in contract number HHSM-500-2007-000231/0002 (DEHPG Data Systems Support).

Description: The purpose of this task order is to collect accurate data and analyze it in a timely manner. The Waiver Management System (WMS), in line with E-GOV initiatives, is critical to the transformation of a current paper-based process to a more efficient electronic system. The WMS has been developed to manage Medicaid program information in a Web-based data warehouse. Web and e-mail tools will facilitate workflow automation through direct report submissions, notifications and alerts making the process more efficient for states and the federal government. The Grant On-line Management Database (GMD) System was developed and implemented under this task order to facilitate implementation, progress, and quality reports on specific grant programs. ■

Washington "Take Charge" Demonstration

Project No: 11-W-00134/00
Project Officer: Thomas Hennessy
Period: March 2001 to March 2010
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: As of September 30, 2009, 41,313 individuals received family planning services through Washington's "Take Charge" family planning demonstration. On October 5, 2009, Washington requested a 3-year extension. The request approval is pending.

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, CHIP, or Medicare, and who have family income at or below 200% Federal Poverty Level (FPL). ■

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: Wanda Pigatt-canty
Period: January 1999 to March 2010
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: In January 2009, Wisconsin withdrew its requests for amendments to the demonstration submitted on July 8, 2008. The demonstrations expires on March 31, 2010 and the state has not yet indicated whether it will seek an extension.

Description: BadgerCare was created as a health insurance program for low-income working families with children. BadgerCare is intended to provide health care coverage to families with incomes too high for Medicaid and who do not have access to affordable health insurance. By extending health care coverage to uninsured low-income families, BadgerCare originally sought to provide a safeguard against increasing the number of uninsured families and children as a result of Wisconsin's welfare reform program. BadgerCare is designed to bridge the gap between low-income Medicaid coverage and employer-provided health care coverage. Demostration participants receive the full Medicaid benefit package; in addition, the state can elect to pay premiums for employer sponsored health plans for BadgerCare eligibles if the cost is less than enrollment into the BadgerCare program. As reauthorized in May 2007, demonstration participants included children to age 19 with incomes of 100-200% federal povery level (FPL) (title XXI funded), parents with incomes up to 130% FPL (title XIX funded), and parents with income between 130% and 200% FPL (title XXI funded). Since that approval, Wisconsin has made several changes to its Medicaid and CHIP state plans, rendering many of the waiver authorities that were granted unnecessary. The state also has ceased claiming title XXI funds for parents, effective April 1, 2008. CMS is working with Wisconsin to amend the demonstration to take account of these state plan changes. ■

Wisconsin BadgerCare Plus Health Insurance for Childless Adults

Project No: 11-W-00242/05
Project Officer: Wanda Pigatt-canty
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: The demonstration implemented an enrollment cap, effective October 1, 2009.

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 percent of the Federal Poverty Level (FPL). The program includes new and innovative features, including centralized eligibility and enrollment functions, a 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, the tiering of health plans based on quality of care indicators, and 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 December 2010
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: On October 2, 2009, Wisconsin requested an amendment to the demonstration to provide family planning services coverage to men, women with existing health insurance coverage, and to provide presumptive eligibilty; these requests are pending. As of December 31, 2009, 56,093 individuals received family planning services through the demonstration.

Description: This demonstration provides family planning services to women between the ages of 15 and 44, with income at or below 185% Federal Poverty Level (FPL), who are not otherwise Medicaid eligible. ■

Wyoming 'Pregnant By Choice' Demonstration

Project No: 11-W-00238/08
Project Officer: Thomas Hennessy
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 September 30, 2009, 290 individuals received coverage for family planning services through 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% Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid, CHIP, 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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