Frontier Community Health Integration Project

Demonstration Design and Solicitation

I. Background

Section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as amended by section 3126 of the Affordable Care Act (ACA) of 2010, authorizes a Demonstration project on community health integration models in certain rural counties to develop and test new models for the delivery of healthcare in order to better integrate the delivery of acute care, extended care and other healthcare (as defined in section 123) and thereby improve access to care for Medicare and Medicaid beneficiaries residing in very sparsely populated areas.

The authorizing legislation defines distinct roles for this Demonstration for the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) in developing and implementing this project. HRSA was charged with awarding grants to eligible entities for the purpose of technical assistance and informing the Secretary on the specific needs of frontier communities, while CMS is to conduct a Demonstration testing alternative reimbursement and administrative strategies.

This Demonstration is commonly known as the Frontier Community Health Integration Project (FCHIP). CMS is hereby requesting applications for participation in this Demonstration from eligible entities as defined in Section 123(d)(1)(B) of MIPPA. CMS interprets the eligible entity definition as meaning critical access hospitals (CAHs) that receive funding through the Rural Flexibility Program. The statute limits the Demonstration to no more than four States; it further restricts eligibility to CAHs in States in which at least 65 percent of counties have population densities of six persons or fewer per square mile. Thus, the applications to participate in this Demonstration will be limited to CAHs in Alaska, Montana, Nevada, North Dakota, and Wyoming, and CMS will select participants from no more than four of these States.

The authorizing legislation mandates that the project last for 3 years. The law authorizes waiver of such provisions of the Medicare and Medicaid programs as are necessary to conduct the Demonstration project. The authorizing legislation also requires the Demonstration to be budget neutral, that is, to be structured such that Medicare expenditures under the Demonstration do not to exceed the amount which the Secretary estimates would have been paid if the Demonstration project were not implemented. This request for applications describes CMS' project guidelines, conditions of participation, payment methodology, and application instructions.

The FCHIP Demonstration is designed to improve access to certain services, the delivery of which is often not feasible at low volumes under current Medicare reimbursement, but which, if integrated into the local delivery system, would lead to improved outcomes and greater efficiency in healthcare service delivery. Integration of services is intended as an intervention that is directed by the various providers serving the community so that the specific healthcare needs of residents are addressed in appropriate settings – either inpatient, outpatient, or at home. The desired outcome is to increase access to certain services so as to allow them to be financially feasible given the low patient volumes of a remote and sparsely populated area. Another objective is to decrease both the number of avoidable hospital admissions, readmissions, and avoidable transfers to tertiary facilities, such that there is no net increase in Medicare spending for the affected population.

To address these twin goals of increasing access and no net cost increase, we have identified four types of services for which this Demonstration will enhance financial support, and thus promote community health integration – these are: skilled nursing care, telemedicine, ambulance, and home health. We have selected these services on the basis of research and literature review. Applicants are being asked to specify new provisions of these types of services that address the need for and quality of care, while also enhancing patient care options and the ability of beneficiaries to remain in their communities, when care can safely be provided locally.

II. Statement of the Problem

Critical Access Hospitals were introduced in 1997 as a provider type under Medicare to support essential care in rural areas. Because low patient volumes might otherwise impede financial sustainability, Medicare reimbursement for inpatient and outpatient services is based on reasonable costs, not on the inpatient and outpatient prospective payment systems, which apply to most US hospitals. Nonetheless, CAHs in the most remote and sparsely populated areas face financial challenges, in part on account of not receiving cost-based reimbursement for services that do not directly relate to hospital-based care, such as home health, ambulance services (in certain situations) or stand-alone nursing facility services. These services may not be financially feasible at very low volumes under standard reimbursement methodologies, although they might otherwise play an essential role in healthcare delivery for the community.

CAHs are the hubs for healthcare activities in frontier areas, but often they serve few inpatients. Although it is difficult to generalize on the extent of healthcare needs for diverse communities, evidence from current research provides that during the past 15 years, a substantial number of nursing facilities have closed, suggesting that there may be a gap in availability of

such services in frontier areas.[1] Factors that might explain provider shortages include trends of decreased reimbursement, as well as scale disadvantages associated with declining populations.

In addition, CAHs and other frontier providers face challenges recruiting and retaining physicians and nurses, meeting the financial costs of recruiting, and training new and recent nursing graduates to achieve the level of competency needed to address community needs. These providers are often staffed by general practitioners with few specialists.

III. FCHIP Model

- **Provisions**

To apply, CAHs must meet the eligibility requirements in the authorizing legislation in section 123 of MIPPA specified in section V.B. below. In addition, they will be required to describe a proposal to enhance health-related services so as to complement those currently provided by the CAH and reimbursed by Medicare, Medicaid, or other third-party payers. The applicant must describe an integrated system of services and explain how these will better serve the community's health-related needs. These enhanced services may include:

- Telemedicine;
- Nursing facility care within the CAH (in addition to the 25 beds currently allowed);
- Home health services; and
- Ambulance services.

Under the Demonstration, Medicare will provide additional resources to the CAH, and potentially ambulance services and home health agencies,for these services, inasmuch as

[1] Gale, John A., et al. "Why Do Some Critical Access Hospitals Close Their Skilled Nursing Facility Services While Others Retain Them?" Flex Monitoring Team, Working Paper# 31, and November 2012.

currently unmet need in the community and a proposal to address that need are demonstrated. Applicants will be required to provide evidence for linkages (either ownership or contractual) with the providers of these additional services, e.g., nursing facility, home health agency, ambulance service. Specifically, to be approved for payment of telemedicine services under the Demonstration's payment methodology, the applicant must provide evidence of effective arrangements with distant site specialists who will participate in telemedicine linkages with providers within the community. In addition, to be approved for ambulance services, applicants must show transfer arrangements with essential providers.

The following table details the additional resources to be provided under the Demonstration, specifically, waivers to both Medicare payment rules and conditions of participation for specific services:

Integrated Service Concept	***Payment Waivers to Be Offered***	***Conditions of Participation Waivers to Be Offered***
Telemedicine Services: Originating site fee	CMS will modify the payment to the originating site (presenting patient located at the CAH) specified under section 1834(m)(2)(B) to allow for cost-based payment of the facility fee. Enhanced (cost-based) Medicare reimbursement to the CAH telehealth originating site will be limited to staffing and overhead costs associated with providing this service.	N/A

Integrated Service Concept	*Payment Waivers to Be Offered*	*Conditions of Participation Waivers to Be Offered*
	Enhanced Medicare reimbursement will not be allowed for purchases of new equipment. The payment to the distant site provider will be made under the current physician fee schedule. The provision of telemedicine services will be limited to the currently approved set of physicians and practitioners and the currently specified telehealth services that are allowed under section 1834(m) of the Social Security Act and corresponding Medicare regulations.	
Telemedicine Services: Asynchronous Store and forward	CMS will allow Medicare reimbursement to a CAH originating site and a distant site provider for telehealth services furnished using asynchronous "store and forward" technology as cited in the Medicare Benefit Policy Manual Chapter 15 270.3 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf) for federal telemedicine Demonstrations programs conducted in Alaska and Hawaii. Apart from the waiver	N/A

Integrated Service Concept	*Payment Waivers to Be Offered*	*Conditions of Participation Waivers to Be Offered*
	allowing these services to be provided in the States eligible for the FCHIP demonstration, the provisions of section 1834(m)(1) of the Social Security Act and corresponding regulations will apply.	
Ambulance Services	CMS will waive the 35 mile rule for cost-based reimbursement of ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH in these frontier communities to allow for alternative reimbursement for ambulance services furnished by CAHs participating in the demonstration, even if there is another ambulance service within a 35-mile drive of the CAH or the entity owned and operated by the CAH. Under such circumstances, cost-based reimbursement will be allowed, but not for any new capital (e.g., vehicles) associated with ambulance services.	N/A
Expansion of the limit on the	Medicare cost-based reimbursement principles for CAH swing-bed services	Increase the bed limit for CAHs from 25 beds to 35 beds. The

Integrated Service Concept	*Payment Waivers to Be Offered*	*Conditions of Participation Waivers to Be Offered*
number of beds for the Critical Access Hospital	(reimbursement at 101 percent of reasonable cost) will apply for the staffing costs associated with additional beds in the facility. Additional capital expenditures will not be allowed under this provision.	additional beds can only be used for SNF- or NF-level services - in accordance with standard Medicare and Medicaid reimbursement principles. Capital costs for new construction will not be permitted. *Only sites demonstrating occupancy greater than 80 percent will be eligible for this waiver. Also, this waiver will not be permitted for CAHs that currently operate a distinct-part skilled nursing facility.*
Home Health Services	An enhanced payment rate to account for the costs to travel extended distances to render home health services to patients. The payment rate for miles traveled will be $1.054 per mile, up to a maximum of $1,680 per episode. All standard Medicare requirements pertaining to home health payment, Conditions of Participation, medical necessity, and	N/A

Integrated Service Concept	*Payment Waivers to Be Offered*	*Conditions of Participation Waivers to Be Offered*
	survey and certification will apply.	

- **Payment Principles**

The following are principles that will guide CMS in evaluating the appropriateness and effectiveness of enhanced Medicare payment under the Demonstration. We seek to limit the amount of Medicare payment on the basis of appropriateness of the proposed project to meet community healthcare needs and the feasibility for offsetting savings.

- We will identify a base amount – calculated as the average of the total amount of the CAH's Medicare costs for inpatient services for each of the three immediately preceding years prior to this solicitation for applicants, divided by the average number of inpatient discharges for each of the 3 years, resulting in a base-cost amount per discharge. We will evaluate proposals for enhanced Medicare payments in light of this base amount to assess that there is not an unreasonable increase in cost to Medicare and that the overall amount of reimbursement is proportional to the service needs of the community. Increases in Medicare spending must be weighed against actual savings to the Medicare program in order to meet statutory budget requirements for the Demonstration. The requirement for overall budget neutrality will be a factor in the evaluation of

proposals. Beyond the application process, we will continue to work with CAHs to make sure that their enhanced payments are reasonable given the budget constraints.

Medicare reimbursement for outpatient services will not be affected by the Demonstration. CAHs that participate in the Demonstration will be able to participate in "Method II/Optional Method" reimbursement for outpatient services, under which payments for professional services that are furnished by a physician or other practitioner who has reassigned his or her billing rights are made to the CAH based on 115 percent of the applicable Medicare physician fee schedule amount.

- Under direction from CMS, the Medicare Administrative Contractor will be required to operationalize a system change according to which services for non-hospital providers, such as home health agencies, that are receiving enhanced Medicare reimbursement under the Demonstration, will be disqualified from separate billing for the specified services under either Parts A or B.
- No new construction will be allowed under Medicare payment. Modifications or repairs (e.g., electrical work) will be permitted, but there can be no construction of any facility or areas within a facility.

Specific to telemedicine:

CMS is seeking to enhance integration of telemedicine services into frontier delivery systems, but will not be providing upfront investment for CAHs that do not currently have the capability or equipment to provide these services. We, however, encourage applicants to seek funding for the equipment that may not currently be in place. Cost-based payment

under the Demonstration will apply to costs for the maintenance of equipment, maintenance of technical components, and the originating site facility expenses. (Under current Medicare payment rules, if CAHs are the originating site for telemedicine services, they are reimbursed separately from the cost-based reimbursement methodology and the payment amount is 80 percent of the originating site facility fee).

Specific to ambulance services:

Cost-based payment under the Demonstration will apply to the costs of salaries for emergency staff.

- **Conditions of Participation**

The authorizing legislation allows the Secretary to waive such requirements of Titles XVIII and XIX of the Act as may be necessary and appropriate for the purpose of carrying out this Demonstration. While conducting research on health issues in frontier areas and evaluating policy options consistent with the statutory mandate, we have identified one Medicare condition of participation that may be modified for the goals of increasing access to care and reducing costs, i.e., allowing additional nursing facility beds for critical access hospitals with high occupancy. In implementing this provision, we seek to allow flexibility in the provision of services while at the same time maximizing patient safety. Except for this explicitly identified change to the conditions of participation, providers are required to meet

all established federal and state requirements. In particular, if an applicant chooses the payment enhancements for either ambulance or home health services under the demonstration, it must adhere to all CMS conditions of participation for these services.

- **Plan for Implementation and Operations**

The demonstration will be administered through the following activities:

• Changes to Medicare payment rules will be managed through a CMS Change Request.

• The CMS Medicare Demonstrations Program Group will manage a technical assistance contract with a firm specializing in rural health.

• Terms and conditions will stipulate monitoring, accountability, and milestones – to be enforced through reports (Quarterly or semi-annual) and conference calls

The HRSA Office of Rural Health policy will be involved in all communications with providers and communities.

III. Evaluation and Reporting Requirements

CMS plans to award a contract to an independent research organization to evaluate the FCHIP Demonstration. The evaluation is expected to use mixed methods including qualitative and quantitative studies to examine the development, implementation, and on-going experience of participating sites. Using Medicare and Medicaid administrative data as appropriate, it will also include a study of the Demonstration impacts on the experience of beneficiaries residing in the affected communities, their utilization and total costs of care, and provider experiences in

comparison with other similar providers and beneficiaries not participating in the Demonstration. The evaluation contractor will develop appropriate metrics to measure quality improvement.

Awardees for the Demonstration will be required under the terms and conditions of award to cooperate with our evaluation contractor. The evaluation will be concurrent with the Demonstration and will continue beyond the Demonstration period in order to include in the final report all Demonstration data as reported through the end of the Demonstration period. As part of the Demonstration terms and conditions, participating CAHs must agree to submit to CMS or its contractors data on beneficiaries within the service areas affected by the Demonstration, such as, but not necessarily limited to, information on pre-admission referral sources, lengths of stay, patient demographic data, discharge placement including transfers to other hospital or extended care facilities, Medicare costs, as well as data and documents on the implementation, management and administration of the Demonstration. For the evaluation, participating CAHs shall submit data and provide access for interviews, but will not be expected to conduct claims data analysis.

IV. Technical Assistance

CMS will provide specific technical assistance, through a contractor, to support participating organizations in developing contractual agreements and other arrangements with tertiary facilities toward the ends of collaboration, reduced costs, and improved outcomes. The goal of providing this technical assistance is to help in assisting and educating CAHs and other providers both within and outside of the immediate area around providing patient-centered care. The focus of these activities will be on the coordination of CAHs with tertiary centers, home

health agencies, and other essential providers in frontier communities and the necessary collaboration on steps toward more integrated and patient-centered care. Activities will include participant information sharing and periodic harvesting of lessons learned.

V. Submission of Applications

A. Purpose

This notice solicits applications for Demonstration projects that increase the opportunity for Medicare beneficiaries to receive necessary healthcare services within integrated delivery systems for eligible counties, as defined by the authorizing legislation. The Demonstration aims to test the effectiveness of such integrated models in improving healthcare outcomes, supporting care within the community, and thus increasing access with no net increase in cost to Medicare or Medicaid.

B. Eligible applicants

In accordance with the statute authorizing this Demonstration, an eligible entity must be located in a state in which at least 65 percent of the counties have six or fewer persons per square mile and must be a Rural Hospital Flexibility program grantee. According to an analysis by CMS, CAHs located in Alaska, Montana, Nevada. North Dakota, and Wyoming meets the eligibility requirement for this Demonstration, although CMS will limit participation to four of those states.

C. Application Requirements

Each applicant CAH may submit no more than one application regardless of the number of other providers and suppliers included in the proposal. Along with this application, which will demonstrate the commitment of the CAH to the project, the applicant must include letters of commitment that show agreement with the proposed clinical and financial arrangements from partner organizations, such as home health agencies, rural health clinics, independent physician practices, ambulance services, or nursing facilities, and State Medicaid agencies in the case that changes to provisions of long-term care are included in the proposal.

If an applicant chooses to omit these kinds of providers, it must document either that no such provider exists in the community or that the provision of the services of such provider type is adequate to meet current needs. The applicant must provide information about any grants or demonstration-related arrangements that it currently has with CMS or other state and federal agencies that may be overlapping with the interventions to be supported by this Demonstration. The applicant must also disclose any program integrity actions taken against the applicant or its partners, as well as any information necessary to conduct program integrity screening of the applicant and its partners.

Queries for the narrative portion of the application should be submitted by email to

FCHIP@cms.hhs.gov.

DATES: Applications will be considered timely if we receive them on or before **5:00 PM (ET) May 5, 2014.**

ADDRESS: Mail one unbound original and two copies to:

Centers for Medicare & Medicaid Services
Attention: Steven Johnson
7500 Security Boulevard
Mail Stop: WB-06-05
Baltimore, Maryland 21244

In addition, an email copy in MS Word or PDF must be sent to: FCHIP@cms.hhs.gov.

D. Evaluation Process and Criteria

If the application meets the eligibility requirements of the authorizing legislation and responds to all components of the solicitation, it will be referred to a review panel of technical experts for evaluation and scoring based on the rating criteria specified in this section, and the ranking of all applications along with a written assessment of each application. CMS will design measures to gauge reduction in the number of avoidable transfers. In addition, we will conduct a financial analysis of the recommended proposals and evaluate the proposed projects to ensure that they will be budget neutral.

The evaluation criteria and weights are described below. These criteria are intended to identify specific information that will be useful for evaluating the applications for the Demonstration.

1. Purpose of Project/Statement of Problem and Technical Approach (40 points)

    a) The applicant will be evaluated on how it defines the purpose of the FCHIP Demonstration, that is, the specific goals and objectives to be achieved, and how participation will lead to these goals. A successful applicant should include how the current system of care delivery operates and whether there are gaps in quality or care delivery. The applicant should describe the general patient experience and health

status for populations served. In addition, the applicant should identify the healthcare providers that will participate in the Demonstration project and how each one of them will participate in the delivery of more appropriate and cost-effective care to community residents. A successful application should also include specific indicators that would be used to measure achievement of these goals.

b) The applicant should describe the demographics and healthcare needs of its community. The applicant should describe the population within the service area of the CAH including a break down according to age, case mix, and payer status. The applicant should also identify the distribution of healthcare among current providers, and how the current system of care leads to unmet need on the part of patients.

c) The applicant should identify transfer patterns to healthcare sites outside of the community – how many patients, to what providers, for what conditions, and under what circumstances. The applicant should explain how it plans to provide patient-centered care and how healthcare integration will be achieved. The applicant should describe how its' proposed set of service enhancements will reduce avoidable transfers for what conditions and under what circumstances, while also ensuring that all medically necessary transfers occur.

d) The applicant should describe any explicit steps taken so far to support services by community providers that enhance patient choice and patient safety.

e) If the applicant is proposing to enhance telemedicine or ambulance services to increase access and reduce total cost of care, it should describe what steps it is proposing to coordinate these services among the CAH, out-of-area hospitals and nursing facilities, and physicians and other community practitioners.

f) The applicant should describe the extent to which its plan for community integration of health services includes the following type of providers or arrangements:

i) *Telemedicine*: If the applicant is seeking support for telemedicine services, it should describe arrangements under discussion or currently in place with specialists at distant sites. The applicant should specify what unmet medical needs currently exist in the community and how that will change under this Demonstration, including a description of the types of patients and conditions that will be treated through telemedicine arrangements. The applicant should describe how a waiver that allows for increased reimbursement will improve access to care, provide better patient-centered care, and reduce costs. The applicant should include among its supplemental materials letters of commitment from individual specialists or specialty groups. The applicant should provide detail on its plans for implementing telemedicine linkages, e.g., the nature of interactive technology and equipment to be used.

ii) *Ambulance:* The applicant should describe current arrangements for ambulance services, and explain how financial support for additional emergency staffing will contribute to the goals of increased access, integration, and cost-effectiveness of the community delivery system. The applicant should describe its transfer relationships with other critical access and tertiary hospitals, and include information on how many transports occur in a year and any seasonal issues that are relevant to meeting the needs of the community.

iii) *Nursing facility care*: The applicant should describe the unmet need for long-term care services (both skilled and nursing facility level), and whether it proposes to add capacity to meet that need. The applicant should describe how a waiver that allows for increased reimbursement will improve access to care, provide better patient-centered care, and reduce costs. To give a sense of current context for long-term care provisions within the community, the applicant should describe the following:

- Is there currently a distinct part nursing facility in the community, and, if so, what is its occupancy rate? Could the need for additional nursing home services be met by expanding the number of nursing home beds within the distinct part facility?
- If there was once a nursing home in the community and it has since closed, the applicant should describe the clinical and financial situation at the time, and whether current circumstances warrant increased investment in nursing home services. If the applicant is proposing to add bed capacity within the critical access hospital, it should demonstrate how such an addition will address currently unmet need without new construction, and include data on recent occupancy rates. The applicant should also state how it plans to address safety issues that might arise from expanding capacity and services, as well as the possible increase in demand for acute care inpatient services. The applicant should also explain why adding bed capacity is more appropriate in meeting needs than home and community services (e.g.,

implementing a Home and Community-Based Services waiver in conjunction with the State Medicaid agency).

iv) Home health: The applicant should describe protocols for utilizing home health services toward the goals of a coordinated system of care delivery with patient choice and cost-effective care as its operating principles. The applicant should describe the average distance that the providers have to travel between provider and patient locations in order to understand why enhanced reimbursement is necessary in meeting the need of the community for home health services. To understand the need in the community for these services, the applicant should answer the following questions:

- What is the current need of home health services in the community? How have beneficiaries been receiving this service in previous years? What is the status of home health agencies in the community?
- What is the relationship between local home health agencies and the CAH? Does the CAH currently provide home health services that are currently not being reimbursed through Medicare? Describe which providers (nurse aides, nurses, etc.) provide the home health services for the CAH.

g) The applicant should describe the proposed roles of physicians, case managers, and other staff, such as physician assistants, advanced practice, registered, and licensed practical nurses, community health workers, emergency medical technicians, and paramedics in planning for the integration and coordination of care for patients within the community.

This description should include the methods of training to ensure that these practitioners care for patients in a cost-effective manner, but also in one that ensures the safety of patients. Considering that a goal of the Demonstration is to decrease avoidable transfers, the applicant should describe how its practitioners receive training and gain experience pertaining to clinical appropriateness in transfer decisions.

2. Organizational Capacity/Ability to Implement (35 points)

The central component of the Demonstration will be the CAH, which must demonstrate that it has developed relationships and project plans to integrate services with other providers within the community. The applicant should also describe arrangements for coordinating patient transfers and other health services with hospitals outside of the immediate community.

Applicants must be in compliance with state laws and regulations. The applicant's organization will be evaluated on the basis of its ability to effectively develop and implement this Demonstration project, its description of its planning and development, evidence of integration in the form of agreements between the CAH and providers both within the community and outside of the area for enhancing services to meet patients' healthcare need. If the applicant's proposal requests changes to Medicaid rules for payment or survey and certification, especially as pertaining to increasing the number of beds within a CAH, is required to have letters of support from the State Medicaid agency. Applicants must describe a commitment of administrative resources to execute and complete this project, and to work with CMS and its contractors in monitoring safety, health outcomes, and Medicare and Medicaid costs, as well as documenting and sharing qualitative and quantitative lessons, practices and progress from the Demonstration activities.

Specifically, CMS is planning to work with an evaluation contractor to assess access and cost impacts. Additionally, the applicant should describe the extent to which it has staff and equipment to meet the Demonstration's requirements and that it will fully work with CMS and its contractors on analyzing clinical and claims data.

3. Budget Neutrality Projection (25 Points)

The applicant should submit an analysis of how its proposed project will be budget neutral and/or achieve cost savings. This will include projections of the number of patients that will gain access to services within the community that are supported by the Demonstration, the cost of these services, and the resulting cost savings from averting unnecessary transfers to out-of-area hospitals and/or avoidable hospitalizations. The applicants should quantify the incremental costs that will be incurred under the Demonstration relative to current reimbursement and to quantify how its proposed changes will translate into savings. If there are other sources of cost savings, the applicant should explain these.

During the application period, CMS will provide more specific guidance and templates on how to format the budget neutrality analysis. Although the evaluation of the demonstration will be conducted by an external contractor, we encourage applicants to

make the most use of claims and financial data to define the costs of interventions, as well as the potential savings from averted transfers and hospitalizations.

The format for the budget neutrality analysis should present a comparison of Medicare costs with the demonstration and Medicare costs absent the demonstration, and demonstrate that the expenditures as resulting from the demonstration, including enhanced Medicare reimbursement for the CAH, telehealth, ambulance, and home health, and minus the amount saved from averted transfers and hospitalizations, do not exceed the Medicare payment that would occur without the demonstration, i.e., status quo.

The following table outlines *suggested* types of information applicants should include in presenting the budget neutrality analysis. Applicants should provide as much detail as possible on clinical and financial projections. We may work further with applicants on specifying these items, once applications are received.

Integrated Service Concept	**With Demonstration**	**Without Demonstration**
Telemedicine	• Total number of Medicare telemedicine cases per year • Originating site cost-based Medicare payment for telemedicine (including staff and overhead costs)	• Total number of Medicare telemedicine cases • Originating site Medicare telemedicine fee per case • Distant site Medicare telemedicine fee per

Integrated Service Concept	**With Demonstration**	**Without Demonstration**
	• Distant site Medicare telemedicine fee per case • Associated Medicare staff costs • Associated Medicare overhead costs • Number of transfers • Price for each transfer • Information on the types of and costs for the cases for which transfer to tertiary care hospital will be averted	case • Number of transfers (Those that could be appropriately averted) • Price for each transfer
Ambulance	• Total number of Medicare ambulance transports • Cost for each CAH transport • Information on the kinds of cases according to which hospitalizations	• Total number of Medicare ambulance transports by CAH per year. • Fee schedule reimbursement amount for each CAH transport

Integrated Service Concept	**With Demonstration**	**Without Demonstration**
	averted on account of increase in ambulance transports, and what sort of ambulance intervention is leading to averted hospitalizations • Number of averted transfers • Reduced costs associated with averted transfers	
Nursing facility beds	• Total number of Medicare swing bed days • Medicaid payments for swing bed days • Medicare reimbursable costs for original 25 beds • Medicare costs of staff for additional beds • Costs of modifications or repairs	• Total number of Medicare swing bed days • Medicaid payments for swing beds • Medicare reimbursable costs for up to 25 beds

Integrated Service Concept	**With Demonstration**	**Without Demonstration**
	• Information on savings to Medicare arising from not treating additional patients as inpatients (either in acute or nursing facility setting)	
Home Health	• Number of home health visits provided • Amount of Medicare reimbursement for home health visits • Average number of miles traveled per visit • Payment made as a result of demonstration for miles traveled • Information on cases for which hospitalization is averted • Information on savings in Medicare costs for	• Number of home health services provided • Amount of Medicare reimbursement for home health visits • Hospitalizations associated with patients receiving home health services. • Medicare payment for hospitalizations associated with patients receiving home health services

Integrated Service Concept	**With Demonstration**	**Without Demonstration**
	averted hospitalizations	

The applicant will be evaluated on the plausibility of assumptions, reasonableness of the analysis, the extent to which projections are supported with clinical evidence and accounts of community interactions, and the sensitivity of cost outcomes to the stated assumptions of change in services and patient behavior. The analysis should identify the risk factors that might prevent objectives from being achieved.

Collection of Information Requirements:

This information collection requirement is subject to the Paperwork Reduction Act of 1995. This specific collection is approved under OMB control number 0938-0880 entitled "Medicare Waiver Demonstration Application." Applicants must submit the Medicare Waiver Demonstration Application to be considered for this program.