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2006 Edition

Active Projects Report

Research and Demonstrations in Health Care Financing

Theme 3

Expanding Beneficiaries' Choices and Availability of Managed Care Options

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Theme 3: Expanding Beneficiaries' Choices and Availability of Managed Care Options

Summary: The 1990s were marked by dramatic changes in the health insurance marketplace. More recently, as a result of consumers' demand for more flexibility and choice, there has been a shift in managed care enrollment toward less restrictive managed care delivery systems such as Preferred Provider Organizations (PPOs) and Point of Service (POS) plans. CMS is working to develop a variety of flexible health plan demonstrations to reflect changes in the health care market, test new ideas for improved services, and develop new alternatives to traditional fee-for-service Medicare.

Actuarial Assessment of PACE Enrollment Characteristics in Developing Capitated Payments

Project No: 500-95-0061/09
Project Officer: Frederick Thomas
Period: September 2000 to May 2004
Funding: $120,460
Principal Investigator: James Robinson
Award: Task Order
Awardee: University of Wisconsin - Madison
750 University Avenue
Madison, WI 53706

Description: The BBA (1997) requires the PACE program to be paid using the risk adjustment method developed for Medicare+Choice programs, but adjusted for factors specific to the PACE program. PACE is expected to differ from M+C plans in a number of attributes: enrollment size, group bias, dual Medicaid capitation, and mortality rates. An actuarial assessment is needed to explore the risk characteristics related with these factors and to formulate options that use this information in a capitated payment system.

Status: A final report was submitted and accepted in 2004. ■

Administration of the PACE Health Survey

Project No: 500-00-0030/03
Project Officer: Louis Johnson
Period: September 2001 to December 2005
Funding: $1,033,894
Principal Investigator: Edith Walsh
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The purpose of this project is to implement the PACE Health Survey, a variant of the Health Outcome Survey for organizations that serve special populations. In 2003 and 2004, the PACE Health Survey was implemented for the PACE Program. The survey collected functional impairment information that supported frailty-adjusted Medicare capitation payments to PACE organizations for 2004 and 2005, respectively.

Status: During 2004, the PACE Health Survey was administered to enrollees of 27 PACE organizations. The overall response rate was 75 percent, with plan response rates ranging from 56 percent to 92 percent. These response rates were consistent with the response rates achieved for the PACE Health Survey in 2003. The functional impairment information collected by the 2004 PACE Health Survey was used to determine the frailty adjuster for each PACE organization for the purposes of Medicare payment in 2005. ■

Data Collection for Second Generation S/HMO

Project No: 500-96-0005/02
Project Officer: Thomas Theis
Period: November 1996 to December 2004
Funding: $8,978,005
Principal Investigator: Lisa Maria Alecxih
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Description: This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. The work was done by Mathematica Policy Research under a subcontract. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. 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. In addition, this project supports two congressionally mandated reports to Congress, a S/HMO Transition Report to Congress, and a Final Report to Congress on the S/HMO II project. While multiple sites were originally planned for this demonstration, only one--the Health Plan of Nevada--actually implemented a S/HMO II plan. The evaluation was designed to assess the impact of the S/HMO II by comparing it with regular Medicare+Choice sites using measures of utilization, quality of care, and changes in participant health status over time.

Status: The Reports to Congress have been prepared. The S/HMO Transition Report was released to Congress in February, 2001. The second report to Congress, a Final Report to Congress on the S/HMO II project, was released in February 2003. ■

Data Collection for the Second Generation S/HMO Demonstration

Project No: 500-01-0025/03
Project Officer: Thomas Theis
Period: September 2004 to September 2006
Funding: $2,135,312
Principal Investigator: Todd Ensor
Award: Task Order (ADDSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Description: CMS and HCFA have been conducting the Social HMO Demonstration since 1985. It was implemented in response to section 2355 of Public Law 98-369 (the Deficit Reduction Act of 1984) which authorized the Secretary 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. The work was done by Mathematica Policy Research under a subcontract until Fall 2004. However,Mathematica is now conducting this data collection work under its own contract. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. 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.

Status: The project data collection work is continuing. ■

Design and Test of Evidence-Based Communications Strategies to Increase Consumer Awareness and Understanding of Long-Term Care Options

Project No: 500-96-0006/03
Project Officer: Ted Chiappelli
Period: September 2000 to May 2005
Funding: $7,095,615
Principal Investigator: Brian Burwell
Keith Cherry
Award: Task Order
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Description: The object of this program will be to provide Medicare beneficiaries with information about their long-term care options, information on Medicaid long-term care policy, service delivery options and how to access information and assistance. This project will (1) document what is known about consumer understanding of long-term care issues in order to help beneficiaries with awareness of and how to provide useful and understandable information; (2) pilot test a variety of culturally competent community-based communication and assessment activities related to long-term care planning and treatment options; (3) have ongoing evidence-based assessments of pilot activities, and (4) have ongoing reporting on the formative research and assessments.

long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. Under a transition plan, CMS extended the demonstration through December 31, 2007. In January 2005, the demonstration's payment methodology will be based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend. In 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that in 2008, when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan. ■

Sub-Zero Premium (BIPA 606) M+C Plan Evaluaton

Project No: 500-95-0057/06c
Project Officer: Victor McVicker
Period: January 2002 to September 2003
Funding: $249,307
Principal Investigator: Mary Laschober
Award: Contract
Awardee: Bearing Point
1676 International Drive
McLean,VA 22102-4828

Description: The contractor conducted a limited evaluation of the new Sub-Zero Premium plans being offered to Medicare beneficiaries by M+C organizations in CY2003. Section 606 of BIPA amended the Social Security Act to permit M+C organizations to offer a reduction of the Medicare standard Part B premium as an additional benefit. This provision took effect January 1, 2003. In CY-2003, six M+C organizations were offering in two states (NY and FL) ten plans with this benefit.

The purpose of this limited evaluation was to learn from beneficiaries why they enrolled in these new M+C plans and what their initial experience was. In addition, we learned from the plans their reasons for offering these plans, their expectations, and their experiences. The contractor had telephone discussions with key individuals at the sub-zero premium plans, reviewed and provided a description of the marketing materials used with this product, and conducted ten focus group meetings at the two areas.

Status: The final report was issued on September 30, 2003. The key findings from this report are:

• Compared to other M+C plans offered in the counties under study, the sub-zero premium products require higher co-payments and offer less generous supplemental benefits, including no or limited prescription drug coverage.

• Some Florida-based beneficiaries and low-income beneficiaries cited the premium reduction as a reason for choosing their sub-zero premium plan. For most beneficiaries either currently or previously enrolled in a sub-zero premium plan, though, the overwhelming driver of their health plan choice was the participation of their personal physician(s) in the plan.

• Enrollees in Florida seemed to view the sub-zero premium plans as interim plans for healthy aged people until they develop more serious health concerns. For such people, the almost $60 per month in savings is a valuable plan benefit.

• In New York, where the reduction was $20 to $30 per month, enrollees considered the reduction insignificant and had not given it much consideration.

The final report is available on the CMS website. ■

90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration, and 10 percent based on the new risk-adjustment system with the additional frailty adjustment. Under a transition plan, CMS extended the demonstration through December 31, 2007. In January 2005, the demonstration's payment methodology will be based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend. In 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that in 2008 when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan. ■

Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research

Project No: 95-P-09103/00
Project Officer: Thomas Theis
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Lucy Nonnenkamp
Award: Waiver-Only Project
Awardee: Kaiser Permanente Center for Health Research
2701 NW Vaughn Street, Suite 160
Portland, OR 97210

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services were provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate - two were health maintenance organizations (HMOs) that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the HMO sites that developed and added a long-term care component to its service package.

Status: Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II used Medicare waivers only. The Balanced Budget Act (1997) extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act (1999) extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice Program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. Under a transition plan, CMS extended the demonstration through December 31, 2007. In January 2005, the demonstration's payment methodology will be based on the CMS-HCC risk adjustment model using a 70/30 percent payment transition blend. In 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that in 2008, when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan. ■

Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan

Project No: 95-P-09104/09
Project Officer: Thomas Theis
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Timothy C. Schwab
Award: Waiver-Only Project
Awardee: SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
P.O. Box 22616
Long Beach, CA 90801-5616

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites originally were selected to participate; of the four, two were health maintenance organizations that have added

The Long-Term Care Awareness Campaign is conducting a five-state pilot project to increase awareness among retirees and near-retirees about planning ahead for long-term care. Research shows that many persons do not want to think about their future long-term care needs and therefore fail to plan appropriately. If individuals and families are more aware of their potential need for long-term care, they are more likely to take steps to prepare for the future. From a public policy perspective, increased planning for long-term care is likely to increase private financing, and may reduce the burden on public financing sources.

The U.S. Department of Health and Human Services (CMS, ASPE, and AOA), is working closely with The National Governors Association, and the National Council of State Legislators to sponsor the Campaign. The five states participating in the pilot project are: Arkansas, Idaho, Nevada, New Jersey, and Virginia. The Campaign represents a unique partnership between the Federal government and the States to offer a consistent message about planning ahead for long-term care.

Status: The Campaign will take advantage of the availability of long-term care awareness materials that were designed, tested, and approved by The Department as part of an earlier awareness effort. The materials consist of the following pieces:

• Tri-fold brochure with tear-out postcard offering the Long Term Care Planning Tool Kit.

• Tool Kit featuring two elements:

• A 28-page brochure describing what is and what is not covered by public programs related to long-term care. The brochure also describes several ways to plan ahead, addressing legal issues, assessing services, and assessing private financing options.

• An audio CD with interviews of persons engaged in several different types of planning activities such as getting a reverse mortgage, buying insurance, or setting up a power of attorney.

• Public Service Announcement featuring a boomer-aged woman who is thinking about her father's long-term care needs when she realizes that she must begin to plan ahead for herself.

• Follow-up postcard reminding consumers that the Tool Kit is available.

The Campaign has three core components. The first component is a letter from the Governor of each state to every household with a member between the ages of 50 and 70. The letter will include the tri-fold brochure described above as well as a toll free number through which the Tool Kit can be requested. Over 2.1 million letters will be sent to target households across the five pilot states. Follow-up postcards to remind those in the target group of the availability of the Tool Kit will also be used. The second component of the campaign is a series of paid media spots to further publicize the tollfree

number for ordering the Tool Kit. Paid media will include television and radio spots selected to maximize exposure in the target audience of 50-70 year-olds. The television spot may be used as is or may be augmented with an introductory message by the participating Governors. The final component of the Campaign is a press event in which each Governor will announce the launching of the campaign.

The core Campaign components outlined above will be supported by a series of state specific activities designed to take advantage of local resources and information dissemination opportunities. The result will be a state specific plan that provides not only broad education materials (the Tool Kit) but which also includes state-specific resources and referrals. Among these State specific activities are the following:

• Augmenting television spots with introductory messages from the Governors;

• Additional distribution of the Tool Kit to State and local senior organizations and providers;

• Enhanced training of SHIP counselors and local Area Agencies on Aging

(AAAs) on long-term care planning and finance options;

• Briefings for State legislators and other state officials;

• Educational activities targeted to private employers on the importance of providing access to long-term care insurance coverage for their employees; and

• Enhancements to long-term care insurance benefit coverage for State employees.

To better respond to the expected increase in public requests for information on how to plan for long-term care needs, CMS provided specialized training and targeted funds for State Health Insurance Assistance Programs (SHIPs) on long-term care financing issues. SHIPs provide counseling support on a wide range of health insurance issues, including Medicare, Medicaid, long-term care insurance, and supplemental insurance options.

The Long Term Care Awareness Campaign is the first effort of its kind to increase public awareness of the need to plan for future long-term care needs. Evaluation activities will be conducted to identify the communication strategies that prove most effective in increasing awareness and promoting increased planning behavior. The lessons gained from the evaluation of the pilot campaign will be used in the design of future long-term care awareness campaigns in other states. Increased interest in promoting long-term care awareness among states is expected as the burden of publicly financed long-term care services under the Medicaid Program continues to escalate. ■

End Stage Renal Disease (ESRD) Managed Care Demonstration: Health Options

Project No: 95-C-90692/04
Project Officer: Sid Mazumdar
Period: September 1996 to December 2005
Funding: $0
Principal Investigator: Jeremy Ginder
Award: Cooperative Agreement
Awardee: Advanced Renal Options
8400 NW 33rd St, 4th. Floor
Miami, FL 33122

Description: The original demonstration program, Advanced Renal Options, tested whether open enrollment of End Stage Renal Disease (ESRD) patients in managed care was feasible with a capitation rate adjusted for age, treatment status, and cause of renal failure, and additional payment made for extra benefits.

Status: As of December 2004, there were 228 beneficiaries enrolled. Data collection for evaluation purposes ended May 31, 2001, at the conclusion of the mandated 3-year period, and the evaluation report is due May 2002. Waivers were renewed for the period June 1, 2001 through December 31, 2002 for residual demonstration enrollees to continue to receive the extra benefits, with CMS paying an unadjusted capitation rate based on the demonstration rate. Waivers were renewed again for the period January 1, 2003-December 31, 2005. ■

ESRD Capitation Demonstration, Evaluation

Project No: 500-95-0059/03
Project Officer: Joel Greer
Period: August 1997 to September 2006
Funding: $2,442,533
Principal Investigator: Robert Rubin
Award: Task Order
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Description: The project uses survey, claims, and medical records data to evaluate the efficacy and cost-effectiveness of permitting Medicare beneficiaries with End Stage Renal Disease (ESRD) to enroll in managed care.

Status: Completed preliminary analyses and a draft report is with CMS. ■

Evaluation of the M+C Alternative Payment Demonstration

Project No: 500-95-0057/06b
Project Officer: Victor McVicker
Period: January 2002 to December 2004
Funding: $683,363
Principal Investigator: Jim Moser
Award: Contract
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

Description: The Medicare+Choice (M+C) alternative payment demonstration was designed to address the declining number of M+C organizations (M+COs) serving Medicare beneficiaries, specifically in areas where only one M+CO is serving the area. The demonstration tests the feasibility of using alternative payment approaches such as risk-sharing or reinsurance models in the M+C program. This evaluation is examining the experience of the six M+COs that began participating in the demonstration on January 1, 2002 and one M+CO that began on June 1, 2002.

Awardee: Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, NV 89114-5645

Description: The purpose of this second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics. The Health Plan of Nevada (HPN) is one of six organizations originally selected to participate in the project.

Status: The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend will be 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. Under a transition plan, CMS extended the demonstration through December 31, 2007. In January 2005, the demonstration's payment methodology will be based on the CMS-HCC risk adjustment model using a 70/30 percent payment transition blend. In 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment will continue through 2007. This extension serves as a transition plan so that in 2008 when the demonstration ends, the organization should be able to convert to a Medicare Advantage plan. HPN is the only S/HMO II model operational site in the demonstration. HPN began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 2004 was over 51,000 members.

The project's final Report to Congress was released to Congress by the Secretary of Health and Human Services in February 2003. The purpose of this report is to present an analysis of the S/HMO II model. ■

Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)

Project No: 95-P-09101/02
Project Officer: Thomas Theis
Period: August 1984 to December 2007
Funding: $0
Principal Investigator: Eli Feldman
Award: Waiver-Only Project
Awardee: Elderplan, Inc.
745 64th Street
Brooklyn, NY 11220

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a

Medicaid program, expansion requires support by state Medicaid programs. With state budgets strained, the basic work to assess the feasibility of implementing PACE programs has been overlooked by some states. This contract will fund up to four state-specific studies to determine PACE feasibility, as well as potential impediments to PACE expansion. The goal is to promote new state interest and identify potential providers interested in PACE program development.

Status: Work is progressing, with the process started to identify participating states and the feasibility study protocol being developed. ■

Refinement of Risk Adjustment for Special Populations

Project No: 500-99-0038
Project Officer: Ronald Lambert
Period: August 2002 to December 2004
Funding: $399,740
Principal Investigator: Gregory Pope
Award: Contract
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The purpose of this project was to refine and further develop a risk-adjusted payment approach for frail populations. This project reviewed and evaluated potential risk adjusters and developed a frailty adjuster for certain managed care plans that serve the frail elderly. The payment approach that was developed involved the application of a frailty adjuster in conjunction with the inpatient and ambulatory model that was implemented in 2004.

Status: CMS implemented the frailty adjuster for Program of All-inclusive Care for the Elderly (PACE) and the Social HMO (S/HMO), Wisconsin Partnership Program (WPP) and Minnesota Senior Health Options/ Minnesota Disability Health Options (MSHO/MnDHO) demonstrations as of January 2004. No changes were made to the frailty factors for the 2005 payment. ■

Refinements to Medicare Diagnostic Cost Group (DCG) Risk-Adjustment Models

Project No: 500-00-0030/04
Project Officer: Melvin Ingber
Period: September 2002 to March 2007
Funding: $1,028,631
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations was developed under contract with CMS (#500-92-0020 Task Order 6) and were then further improved (#500-95-0048 Task Order 3). This task order will test the model for use in special populations to develop satisfactory payment for plans that enroll beneficiaries selectively based on their medical, functional, or institutional condition. The DCG-based models are designed to use demographic and diagnostic information to project expenditures and to provide factors that could be used to multiply the ratebook amounts instead of the demographic factors currently used.

Further work is to be done on a concurrent model and on an institutional model using a larger sample. The ICD-9 tables will be updated to reflect coding changes to keep the model responsive to new codes.

Status: The early work has been completed and the latter projects are in process. Data from 2002 and 2003 have been used to develop a new more refined version of all the components of the HCC model with more disease classes. A much larger sample of institutionalized were included for that segment of the model and an update of the ESRD HCC model has been produced. Work continues to improve prediction for segments of the population with special needs. ■

Second Generation Social Health Maintenance Organization Demonstration: Nevada

Project No: 95-W-90503/09
Project Officer: Thomas Theis
Period: November 1996 to December 2007
Funding: $0
Principal Investigator: Ronnie Grower
Award: Waiver-Only Project

One of these organizations is using a reinsurance model while the other six organizations are using risk-sharing around a targeted medical expense. The evaluation is exploring whether these payment arrangements increased plan revenues and the impacts on the profile of beneficiaries enrolled in the plans and the benefits available to them.

Status: The contractor has submitted the draft final report for CMS review. The final report covers the first two years of the demonstration (2002 and 2003). ■

Evaluation of the Medical Savings Account Demonstration

Project No: 500-95-0057/06
Project Officer: Victor McVicker
Period: September 1998 to December 2004
Funding: $404,640
Principal Investigator: Keith Cherry
Jack Fyock
Award: Task Order
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

Description: This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries.

Status: No insurers have elected to participate in the MSA demonstration. Because Congress has established MSAs as a permanent part of the program, the demonstration is no longer warranted. Therefore, a letter dated December 29, 2004 was submitted to Congress notifying that there would be no report as was required for the MSA demonstration. ■

Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration

Project No: 500-00-0024/05
Project Officer: Victor McVicker
Period: September 2002 to September 2007
Funding: $2,063,493
Principal Investigator: Gregory Pope
Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

Status: The final case study report was submitted and approved in March 2004 and is available on the CMS website. This case study report focuses on the following areas: reasons for participating in the PPO demonstration, design and characteristics of the PPO product, marketing of the PPO product to Medicare beneficiaries, provider issues, and MCO perceptions and comments regarding the PPO demonstration. The contractor has submitted a draft report on the PPO demonstration plan offerings and enrollment. This report addresses three key outcomes of the PPO demonstration: availability of PPOs, plan offerings, and plan enrollment. The contractor has finished conducting the beneficiary survey and will be submitting a draft report in March 2005. ■

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

Project No: 500-00-0033/01
Project Officer: Frederick Thomas
Period: September 2001 to September 2006
Funding: $819,772
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Description: This 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. This 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.

Status: The evaluation is on-going. Field work is expected to begin in Spring 2005. ■

Formative Research and Product Testing of MMA Communications

Project No: 500-00-0037/06
Project Officer: Alissa Schaub-Rimel
Period: September 2004 to March 2006
Funding: $835,655
Principal Investigator: Beth Simon
Kate Heinrich
Fred Fridinger
Award: Task Order (RADSTO)
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

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

Status: The project is underway. ■

Impact of Increased Financial Assistance to Medicare Advantage Plans

Project No: 500-00-0024/17
Project Officer: Victor McVicker
Period: August 2004 to April 2009
Funding: $1,199,931
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

Status: The contractor has submitted a draft design report to CMS for review. ■

Medicare + Choice Alternative Payment (Phase I) Demonstration

Project No: 95-W-00104/09
Project Officer: Jody Blatt
Period: January 2002 to December 2004
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Pacificare Health Systems, Inc.
3120 Lake Center Drive
Santa Ana, CA 92704

Description: With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries.

Program Monitoring of Customer Service and Information Projects

Project No: 500-95-0062/02
Project Officer: Elizabeth Goldstein
Period: September 2000 to June 2004
Funding: $9,596,936
Principal Investigator: Gary Gaumer
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168

Description: The objective is to develop a design to monitor and assess select customer service and information projects in CMS, provide technical support to the CMS Centers/Offices that are conducting the monitoring activities, and develop outcome measures to assess CMS's progress in improving their overall communications with their beneficiaries and other partners over time. The contractor is designing monitoring systems that provide quick feedback to managers regarding the operations, the efficiency, and the effectiveness of our customer service and information activities to promote continuous quality improvement in how we communicate with beneficiaries and those acting on their behalf.

Status: As part of the National Medicare Education Program, CMS (formerly HCFA) must provide information to beneficiaries about the Medicare Program and their Medicare+Choice options. Performance assessment plays a critical part of HCFA's efforts to provide this information. The contractor provided assistance to HCFA in assessing how well we are communicating with our beneficiaries. Specific activities included: conducting a follow-up assessment in six case study sites, continuing to develop an enhanced performance assessment system for the State Health Insurance Assistance Programs, continuing to monitor the Medicare Choices Helpline, assessing the partnership activities through focus groups and interviews, and obtaining feedback on the Medicare & You Handbook through a postcard. The project is now complete. ■

Project to Assist the Patient Advocate Foundation (PAF) in Serving Patients Experiencing Difficulty Accessing Quality Health Care Services, A

Project No: 18-P-92386/03-02
Project Officer: Lyn Killman
Period: July 2004 to June 2006
Funding: $269,253
Principal Investigator: Alan Richardson
Award: Grant
Awardee: Patient Advocate Foundation
700 Thimble Shoals Blvd., Suite 200
Newport News, VA 23606

Description: This grant continues work started under prior year Congressional funding. The objectives of this project is to provide essential services to patients throughout the U.S. through professional case managers who resolve coverage and benefit issues, job discrimination issues, and debt crises matters. Services include assistance regarding preauthorization, coding and billing, insurance appeal process, access to medical procedures, therapeutics and medical devices, expedited application for Social Security disability insurance and federal health programs. Patients eligible for, but not yet enrolled in, Medicare, Medicaid or the State Children's Health Insurance Program (S-CHIP) will be assisted to enroll.

Status: This grant was awarded in FY 2004 and FY 2005, and the project is underway. Final progress report for 18-P-92386/3-01 submitted on 9/12/05. ■

Promoting State Interest in Identifying PACE Markets

Project No: 500-03-0048
Project Officer: Frederick Thomas
Period: September 2003 to March 2005
Funding: $199,970
Principal Investigator: Peter Fitzgerald
Award: Contract
Awardee: National Pace Association
801 North Fairfax
Alexandria, VA 22314

Description: Since the Balanced Budget Act of 1997 made the Program of All-inclusive Care for the Elderly (PACE) a permanent Medicare Program, there has been little program expansion, and the number of PACE sites is still at the 1999 levels. Since PACE is a joint

all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost-sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but four of the participating organizations currently have a risk-sharing arrangement with CMS.

There are currently 35 PPO Demonstration plans in 22 states for the 2004 contract year. Total enrollment in the demonstration products is 94,739 as of April 1, 2004.

Status: Currently operational. Demonstration will terminate December 2005. ■

Modeling M+C Standardized Benefit Packages in Local Markets

Project No: 500-95-0057/06a
Project Officer: Victor McVicker
Period: January 2002 to September 2003
Funding: $184,688
Principal Investigator: Mary Laschober
Award: Contract
Awardee: Bearing Point
1676 International Drive
McLean, VA 22102-4828

Description: The purpose of this project is to explore the feasibility of developing M+C standardized core benefit package and standardized add-on benefit options that plans can choose when designing benefit packages to offer in their service area. The design of the proposed packages is based on the current range of plan offerings in local Medicare markets and on the experiences of other federal, state, and private organizations with developing defined benefit packages. Information on the M+C benefit package was supplemented by key informant interviews and a focused literature review. The proposed packages could be used in a competitive model for Medicare (similar to FEHBP) that increases choices available to beneficiaries.

Status: Final report was issued on September 30, 2003 and is on the CMS website. This report proposes for Medicare 3 model core benefit packages and 4 riders (with 2 options each) resulting in 240 combinations of core and riders that health plans could make available to beneficiaries. For each of the core benefit packages, this report provides the estimated annual cost for plan benefits and the amount paid by the beneficiary as out-of-pocket expenditures, as well as the total paid by the plan and the beneficiary. The report also discusses the advantages and disadvantages of standardization and the alternatives to full standardization. ■

Per-Case Payment to Encourage Risk Management and Service Integration in the Inpatient Acute-Care Setting

Project No: 500-92-0013/05
Project Officer: Mari Johnson
Period: September 1995 to April 2005
Funding: $877,000
Principal Investigator: Janet Mitchell
Award: Delivery Order
Awardee: Research Triangle Institute, (MA)
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

Description: The purpose of this project is to design a demonstration, conduct a solicitation, and provide technical assistance during the implementation of a per-case payment system. Discounted lump-sum payments based on each participating physician hospital organization's historical payment experience for all diagnosis-related groups are made to the representative organization. The demonstration sites are called Medicare physician provider partnerships. The demonstration seeks to measure actual provider behavioral response, patient satisfaction, health outcomes, and overall impact on the Medicare program, given a financial risk-sharing intervention for acute Medicare Part A and Part B inpatient services. This demonstration is intended to provide important understanding about the administrative complexities, their associated costs, and other implementation issues surrounding a medical staff payment approach. This demonstration builds on research conducted under two prior studies (500-92-0020DO07 and 18-C-90038/3) investigating alternative payment options for medical staffs that would promote efficiency and improve service delivery during acute inpatient stays.

Status: The contractor assisted CMS in developing payment rates and savings estimates for the demonstration. Operation of the demonstration was cancelled due to computer systems issues. ■

Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued for 2002. The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C program. The demonstration was initially scheduled to last for two years (2002 & 2003), but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one Private Fee-for-Service Plan (Humana in DuPage County, Illinois), and one employer group-only program incorporating 2 health plans and 3 contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated their M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular M+C plan in these counties. As of March 1, 2004, the remaining active plans had just under 40,000 members.

Status: Demonstration terminated December 31, 2004. Plan continued as regular MA plan in 2005. ■

Medicare + Choice Alternative Payment (Phase I) Demonstration

Project No: 95-W-00105/04
Project Officer: Jody Blatt
Period: January 2002 to December 2004
Funding: $0
Principal Investigator: Douglas R. Carlisle
Award: Waiver-Only Project
Awardee: Employers Health Insurance Company
500 West Main Street, 7th Floor
Louisville, KY 40201

Description: With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued for 2002. The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk-sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C program. The demonstration was initially scheduled to last for two years (2002 & 2003) but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one Private Fee-for-Service Plan (Humana in DuPage County, Illinois), and one employer group-only program incorporating 2 health plans and 3 contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated their M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular M+C plan in these counties. As of March 1, 2004, the remaining active plans had just under 40,000 members.

Status: Demonstration terminated December 31, 2004. Plan continued in 2005 as regular private fee for service plan under Medicare Advantage Program. ■

Medicare + Choice Alternative Payment (Phase I) Demonstration

Project No: 95-W-00106/03
Project Officer: Jody Blatt
Period: January 2002 to December 2004
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: The Health Plan of the Upper Ohio Valley, Inc.
52160 National Road East
St. Clairsville, OH 43950-9365

Description: With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued for 2002. The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk-sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C Program. The demonstration was initially scheduled to last for two years (2002 & 2003) but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one Private Fee-for-Service Plan (Humana in DuPage County, Illinois), and one employer group-only program incorporating 2 health plans and 3 contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated their M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular M+C plan in these counties. As of March 1, 2004, the remaining active plans had just under 40,000 members.

Status: Demonstration terminated December 31, 2004. Plan absorbed into MA coordinated care plan in 2005 with a separate employer-only benefit plan. ■

Medicare + Choice Alternative Payment (Phase I) Demonstration

Project No: 95-W-00108/05
Project Officer: Jody Blatt
Period: January 2002 to December 2004
Funding: $0
Principal Investigator:
Award: Waiver-Only Project
Awardee: Independence Blue Cross
1901 Market Street
Philadelphia, PA 19101-7516

Description: With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued in 2002. The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C Program. The demonstration was initially scheduled to last for two years (2002 and 2003) but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one Private Fee-for-Service Plan (Humana in DuPage County, Illinois), and one employer group-only program incorporating two health plans and three contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated their M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular

network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in

21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91731/04-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Lauralie Rubel
Award: Grant
Awardee: Cariten Insurance Company
1420 Centerpoint Blvd.
Knoxville, TN 37932

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This researched indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the by increasing incentives for M+C organizations to enter the market and offer PPO products.

This demonstration program is modeled after the PPO coverage available in the commercial market. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost-sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but four of the participating organizations currently have a risk-sharing arrangement with CMS.

There are currently 35 PPO Demonstration plans in 22 states for the 2004 contract year. Total enrollment in the demonstration products is 94,739 as of April 1, 2004.

Status: Currently operational. Demonstration will terminate December 2005. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-00127/09
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $0
Principal Investigator: Katherine Feeny
Award: Grant
Awardee: Pacificare of Nevada, Inc.
700 East Warm Springs Road
Las Vegas, NV 98119

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This researched indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the by increasing incentives for M+C organizations to enter the market and offer PPO products.

This demonstration program is modeled after the PPO coverage available in the commercial market. Although

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91739/05-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $50,000
Principal Investigator: Richard Jones
Award: Grant
Awardee: United Healthcare Insurance Company
9900 Bren Road East, Mail Route MN008-T500
Minnetonka, MN 55343

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91799/03-01
Project Officer: Heather Grimsley
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Mary Ninos
Award: Contract
Awardee: Coventry Health Care, Inc.
6705 Rockledge Drive
Bethesda, MD 20817

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of

M+C plan in these counties. As of March 1, 2004, the remaining active plans had just under 40,000 members.

Status: Demonstration terminated December 31, 2004. Plan continued in 2005 as a regular Medicare Advantage (MA) PPO plan. ■

Medicare + Choice Alternative Payment (Phase I) Demonstration

Project No: 95-W-00107/03
Project Officer: Jody Blatt
Period: January 2002 to December 2004
Funding: $0
Principal Investigator: Mary Ninos
Award: Waiver-Only Project
Awardee: Coventry Health Care, Inc.
6705 Rockledge Drive
Bethesda, MD 20817

Description: With enactment of the Balanced Budget Act of 1997 (BBA) came the expectation that the Medicare+Choice (M+C) program would continue to grow and offer additional choices to beneficiaries. Unfortunately, the number of plans and percentage of beneficiaries enrolled steadily declined from a high of 18 percent in 1999. This trend of plans exiting the market continued in 2002. The M+C Alternative Payment Demonstration was designed to take immediate action to test whether alternatives to the current M+C payment systems, in particular various risk sharing and reinsurance arrangements, could be used to encourage M+COs to remain in the M+C Program. The demonstration was initially scheduled to last for two years (2002 and 2003) but was extended an additional year for 2004.

Six new M+C plans were effective under this demonstration on January 1, 2002. They included one PPO (Independence Blue Cross), one Private Fee-for-Service Plan (Humana in DuPage County, Illinois), and one employer group-only program incorporating two health plans and three contracts sponsored by Wheeling-Pittsburgh Steel Corporation. In June 2002, a seventh plan sponsored by United Healthcare of Wisconsin was added to the demonstration. M-Care, which offered a plan in 2002 in Livingston and Washtenaw counties in Michigan, dropped out of the demonstration and terminated their M+C plan effective January 1, 2003. At the request of several plans, a decision was made in late 2003 to allow the remaining plans the option of extending the demonstration for an additional year in 2004. Humana, Pacificare, Independence Blue Cross, and the Wheeling-Pittsburgh plans will be extended. Anthem and United Healthcare of Wisconsin will terminate their demonstration plans but continue to offer a regular M+C plan in these counties. As of March 1, 2004, the remaining active plans had just under 40,000 members.

Status: Demonstration terminated December 31, 2004. Plan members were absorbed into a Medicare advantage (MA) coordinated care plan in 2005 as a separate employer specific benefit plan. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-00113/07
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Mary Ninos
Award: Grant
Awardee: Coventry Health and Life Insurance Company (Earth City)
111 Corporate Office Drive, Suite 400
Earth City, MO 63045

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a

PPO product, and are symmetrical, meaning that the risk assumed by CMS is

the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-0014/07
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Mary Ninos
Award: Grant
Awardee: Coventry Health and Life Insurance Company (Kansas City)
8320 Ward Parkway
Kansas City, MO 64114

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91796/09-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Matthew Woodruff
Award: Grant
Awardee: Health Net Life Insurance Company (Arizona)
2800 N. 44th Street, Suite 900
Phoenix, AZ 85008-1553

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare

year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91742/09-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Katherine Feeny
Award: Grant
Awardee: Pacificare Health Systems, Inc.
3120 Lake Center Drive
Santa Ana, CA 92704

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91733/06-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Carol Solomon
Award: Grant
Awardee: Tenet Choices, Inc.
200 West Esplanade Avenue, Suite 600
Kenner, LA 70065

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

Awardee: Managed Health Inc.
25 Broadway, 9th Floor
New York, NY 10004

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

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CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91734/05-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Tara Flippin
Award: Grant
Awardee: OSF Health Plans, Inc.
7915 North Hale Avenue, Suite D
Peoria, IL 61615

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract

Theme 3

+ Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-00119/09
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Matthew Woodruff
Award: Grant
Awardee: Health Net Life Insurance Company (California)
21281 Burbank Blvd., Building B
Woodland Hills, CA 91367

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

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CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91741/01-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Susan Rawlings
Award: Grant
Awardee: Aetna Health Inc.
Mailstop RT11, 151 Farmington Avenue
Hartford, CT 06156

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C)

program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91729/05-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $0
Principal Investigator: Lynne Gross
Award: Grant
Awardee: Anthem Health Plans of KY, Inc., Community Insurance Company
220 Virginia Avenue
Indianapolis, IN 46204

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91795/04-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Luisa Charbonneau
Award: Grant
Awardee: Humana Insurance Company
500 West Main Street
Louisville, KY 40202

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91737/02-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Michael Honig
Award: Grant

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91800/04-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: David Ellwanger
Award: Grant
Awardee: Health Spring Inc.
44 Vantage Way, Suite 300
Nashville, TN 37228

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91744/02-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Jackie Duddy
Award: Grant
Awardee: Horizon Healthcare of New Jersey, Inc.
3 Penn Plaza East
Newark, NJ 07105-2200

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91797/05-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Janice Teal
Award: Contract
Awardee: Advantage Health Plan, Inc.
11555 N. Meridian Street
Carmel, IN 46032

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-91740/03-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Sandra McAnallen
Award: Grant
Awardee: UPMC Health Benefits, Inc.
112 Washington Place, Suite 800
Pittsburgh, PA 15219

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

Products available under this demonstration were initially offered in contract year 2003. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost-effective manner while not providing a disincentive towards seeking appropriate care. A key feature of this demonstration is a risk-sharing component. Risk-sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings. All but seven of the participating organizations currently have a risk-sharing arrangement with CMS.

CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 States in the 2005 contract year. Total enrollment in the

demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91727/02-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Dennis Gorski
Award: Grant
Awardee: HealthNow New York, Inc.
1901 Main Street
Buffalo, NY 14208

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare Program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice program by increasing incentives for M+C organizations to enter the market and offer PPO products.

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CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-00115/03
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Mary Ninos
Award: Grant
Awardee: Coventry Health and Life Insurance Company (Charleston)
500 Virginia Street East, PO Box 1711
Charleston, WV 25326

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

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CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-W-00116/03
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $0
Principal Investigator: Mary Ninos
Award: Grant
Awardee: Health Assurance Pennsylvania, Inc. (Conventry)
3721 TecPort Drive, PO Box 67103
Harrisburg, PA 17106-7103

Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.

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CMS has contracted with Research Triangle Institute to conduct a comprehensive evaluation of the Medicare PPO Demonstration.

Status: Currently operational. Demonstration organizations are offering 34 plans in 21 states in the 2005 contract year. Total enrollment in the demonstration products is 119,012 as of March 1, 2005. The demonstration will terminate on December 31, 2005. Demonstration organizations are currently preparing to transition to the Medicare Advantage Program in contract year 2006; many are expected to offer local and/or regional PPO products. ■

Medicare Preferred Provider Organization (PPO) Demonstration (Phase II)

Project No: 95-C-91792/02-01
Project Officer: Deborah VanHoven
Period: January 2003 to December 2005
Funding: $100,000
Principal Investigator: Donna Lynne
Award: Grant
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Description: Although the Balanced Budget Act of 1997 (BBA) introduced new health plan options for beneficiaries under the Medicare + Choice (M+C) Program, unfortunately, the number and range of options available have not increased over time. Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare Program. This research indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in the Medicare + Choice Program by increasing incentives for M+C organizations to enter the market and offer PPO products.