2009 Edition

Active Projects Report -

Research and Demonstrations in Health Care Financing

A Comprehensive Guide to CMS's Research Activities -

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The Active Projects Report

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

Access Health

Project No: 1C0CMS030270/01
Project Officer: Jessica Kahn
Period: July 2008 to December 2009
Funding: $191,593.00
Principal Investigator: Jeff Fortenbacher
Award: Grant
Awardee: Access Health, Inc.
1200 Ransom Street, Suite 102
Muskegon, MI 49442

Status: Funds were awarded and accepted by the grantee. The first semi-annual progress report is due January 30, 2009. The first financial report is due Sept. 30, 2009.

Description: The goals and objectives of this grant are to provide health coverage to the lower income working uninsured employees in Muskegon County. ■

Actuarial Research Contract

Project No: 500-03-0021
Project Officer: Clare Mcfarland
Period: September 2005 to September 2008
Funding: $4,135,786.00
Principal Investigator: Beth Jackson
Award: Contract
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale,VA 22003

Status: This contract has ended.

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

ADA and Quality Initiatives

Project No: 500-00-0021/01
Project Officer: Adrienne Delozier
Period: September 2003 to September 2008
Funding: $5,083,486.00
Principal Investigator: Brian Burwell
Award: Task Order (RADSTO)
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: The period of performance ended September 2008. The contract deliverables have been completed.

Description: On June 22, 1999, the U.S. Supreme Court, in Olmstead v. L.C., provided an important legal framework for State and Federal efforts to enable individuals with disabilities to live in the most integrated

setting appropriate to their needs. This decision affirmed that no one should have to live in an institution or nursing home if they can live in the community with the right mix of supportive services for their long-term care. The Americans with Disabilities Act of 1990 (ADA) is both reinforced and clarified with the Olmstead decision. This decision has challenged the Federal Government and States to develop more opportunities for individuals with disabilities to live and participate in the community through more accessible systems of cost-effective community-based services. The Medicaid Program plays a critical role in making long-term care available in the community by offering States many opportunities to deliver this care through mandatory State plan services like home health and optional services such as personal care. In addition, most States rely heavily on the Medicaid 1915(c), 1915(b) and 1115 waiver authorities to provide long-term care in the community. On June 19, 2001, the President released an Executive Order aimed at expanding community-based alternatives for people with disabilities. He directed a number of Cabinet Secretaries, including the Secretary of Health and Human Services (HHS), to "swift(ly) implement the Olmstead Decision (and) evaluate the policies, programs, statutes and regulations … to determine whether any should be revised or modified to improve the availability of community-based service for qualified individuals with disabilities." Each agency head was required to report to the President, through the Secretary of HHS, the results of their evaluation. A preliminary report, entitled Delivering on the Promise, was sent to the President on December 21, 2001. Individual Agency and Department Reports were sent on March 25, 2002. The HHS Report is entitled "Progress on the Promise." This contract supports several tasks that further the goals of the ADA, the Olmstead Decision, and the New Freedom Initiative including: 1. Ensuring Quality in the Medicaid Home and Community Based Services (HCBS) Waiver Program - Provides a National Technical Assistance Contractor for the provision of technical assistance to States, the Centers for Medicare & Medicaid Services (CMS) Central Office, and CMS Regional Offices in the areas of quality management, including quality assurance and improvement. 2. Resource Network for ADA/Olmstead - Supports the website HCBS.org which facilities communication between States and consumers, provides seminal research and summaries on HCBS programs or initiatives, and provides important HCBS data. 3. Olmstead-Informational Tools for States - Funds efforts by the National Conference of State Legislatures to help legislators understand their responsibilities and opportunities to provide cost-effective, high quality community-based services, develop systems that support employment of people with disabilities, and understand then comply with the Olmstead v. L.C. Supreme Court decision. 4. Executive Order Administrative Costs - Will support the logistical planning and convening of two New Freedom Initiative Policy Summits. 5. New Model Waivers - Will develop a training curriculum for CMS to present to States on self-direction in the context of Independence Plus waivers and demonstrations and implementing the required standards. Will also support technical assistance to states on implementation and CMS requirements related to Independence Plus. Option II was exercised in April 2006. ■

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

Project No: HHSM-500-2005-00020I/0001
Project Officer: Carol Magee
Period: September 2005 to September 2009
Funding: $299,780.00
Principal Investigator: Christine Bishop
Award: Task Order (MRAD)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Data analysis for this contract is being performed. A Seminar will be held at CMS in winter 2009, to present preminary findings and elicit CMS expertise toward the final analysis plan.

Description: This task order will conduct analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. This task order was extended an additional year April of 2008. ■

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

Project No: GS-23F-0135L/HHSM-500-2006-00018G
Project Officer: Juliana Tiongson
Period: February 2006 to January 2010
Funding: $275,127.00
Principal Investigator: William Oliver
Award: GSA Order

Awardee: Clifton Gunderson
4041 Powder Mill RoadSuite 410
Calverton, MD 20705

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

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

Alabama Family Planning ("Plan First")

Project No: 11-W-00133/4
Project Officer: Lane Terwilliger
Period: June 2000 to September 2011
Funding: $ 0.00
Principal Investigator: Carol Hermann-Steckel
Award: Waiver-Only Project
Awardee: Alabama, Medicaid Agency
1665 University Blvd., P.O Box 5624
Birmingham, AL 35294-0022

Status: The State was granted a three-year extension for this demonstration in October 2008. As of 9/30/2008, 85,419 individuals were receiving family planning services through the demonstration.

Description: This demonstration provides coverage for family planning services for uninsured women ages 19 through 44 who are not otherwise eligible for Medicaid or other coverage that provides family planning services, and who have family income at or below 133% FPL. ■

Alternative Approaches to Measuring Physician Resource Use

Project No: HHSM-500-2005-00027I/04
Project Officer: Craig Caplan
Period: September 2008 to May 2011
Funding: $1,499,979.00
Principal Investigator: David Knutson
Award: Task Order (RADSTO)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: Project work is underway. The contractor is preparing for formal kickoff meeting and analysis plans.

Description: CMS and others in the policy community have been increasingly interested in moving to a value based purchasing (VBP) system for physicians under traditional fee-for-service Medicare. Under VBP, physicians' payments would depend on the "value" of services provided; physicians who routinely use relatively few resources while maintaining adequate quality would receive larger payment updates than physicians providing similar or lower quality at with more resources. CMS and other groups have focused on the use of commercially developed episode groupers to measure resource use, but little peer reviewed literature that evaluates these groupers exists, and few studies have examined feasible alternatives in Medicare. The purpose of this task order is to suggest and develop alternative approaches to the commercial episode grouper-based physician resource use measures and to examine issues related to implementation of these approaches. ■

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

Project No: HHSM-500-2006-00048C
Project Officer: William Cymer
Period: September 2006 to September 2009
Funding: $1,553,616.00
Principal Investigator: Richard Hirth
Award: Contract

Awardee: University of Michigan Kidney Epidemiology and Cost Center
315 West Huron, Suite 420
Ann Arbor, MI 48103

Status: Option year one and two have been exercised.

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

Application of Episode Groupers to Medicare

Project No: HHSM-500-2006-00006I/05
Project Officer: Fred Thomas
Period: August 2007 to March 2009
Funding: $444,398.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

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

Description: CMS's episode grouper software evaluation began in 2006. Over the last year, there has been a notable evolution in the policy environment related to episodic grouping. In particular, MEDPAC has issued two reports that suggest that episode grouping techniques have the potential to be developed into tools for profiling physician efficiency by identifying physicians whose costs per episode are outside a reasonable range. Various umbrella organizations, such as the Alliance for Quality Activity (AQWA) and the National Quality Forum (NQF), are working to define a set of conceptual standards that can be used in constructing physician profiles. Recently, a GAO study showed that there is substantial cost variation across patients within disease types using annual claims data. An extension of this work is that physician profiles may be generated from claims data to identify those responsible for higher care costs, and then use financial incentives to change this behavior. In light of the continuing policy debate, and to test the application of these concepts in Medicare, this task order will continue the work performed under the Episodic Grouper Evaluation contract by writing a design report for a pilot study; construct physician efficiency profiles; write a report on profiling and result of the modified groupers; and provide programming/analytic support to a complementary clinical logic contract. ■

Arizona Health Care Cost Containment System

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

Status: An amendment was approved in March 2008 to eliminate the "Tamper Resistent Prescription Drug Pad" requirement for fee-for-service populations in the State. In October 2008, the demonstration was amended to allow the State to implement a state-wide premium assistance program for title XXI SCHIP eligible children with access to ESI with a family income above 100% FPL through 200% FPL. An amendment request to expand certain benefits and extend eligibility to additional pregnant women and women transitioning

into the Family Planning Extension Program, originally submitted June 29, 2007, is still pending, awaiting the State's response to a request for additional information.

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

Arkansas 1115

Project No: 11-W-00116/06
Project Officer: Marguerite Schervish
Period: October 1998 to January 2008
Funding: $ 0.00
Principal Investigator: Deborah Ellis
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services Division of Medical Services
PO Box 1437, Slot S401, 700 Main Street
Little Rock, AR 72203-1437

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

Description: The National Cash and Counseling Demonstration was an innovative model of consumer-direction in the planning, selection, and management of community-based personal care and related health services. Consumers were given a monthly cash allowance that they used to purchase the assistance they required for daily living. The Cash and Counseling Demonstration and Evaluation occurred in three States: Arkansas, Florida, and New Jersey. Under the section 1115 demonstration authority of the Social Security Act and the initial design of the program, participants were assigned to a treatment group or a control group. Beneficiaries selected for the treatment group received cash allowances, which they used to select and purchase the personal assistance services (PAS) that met their needs. Fiscal and counseling intermediary services are available to those members of the treatment group who wish to utilize them. Individuals assigned to the control group received PAS services from traditional Medicaid providers, with the State making all vendor payments. Other partners in this collaborative effort included the Robert Wood Johnson Foundation, which funded the development of these projects; the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, which funded the evaluation; the National Program Office at Boston College, which performed various coordinating functions; the University of Maryland's Center on Aging, which conducted ethnographic studies; and the National Council on Aging, which has served in an advisory capacity. An evaluation contract was awarded to Mathematica Policy Research, Inc. Mathematica assessed differential outcomes with respect to cost, quality, and client satisfaction between traditional PAS services and alternative choice modalities. These reports can be found at www.cashandcounseling.org. CMS approved the Arkansas Independent Choices demonstration on October 9, 1998, and implementation began December 1, 1998. Enrollment and random assignment began in December 1998 and continued until the evaluation target of 2,000 enrollees in April 2001. CMS approved an amendment to the program on October 2, 2002. Since that time, the program has met the CMS requirements to be conferred the Independence Plus designation. The amendment allowed Arkansas to end randomization and to extend the program for 3 years. Participants in the control group, and others, have been given the opportunity to enroll in the treatment group. Current participation is about 1,400. On April 26, 2006, the State submitted a request to amend and extend the program. ■

Arkansas Family Planning

Project No: 11-W-00074/6
Project Officer: Lane Terwilliger
Period: June 1996 to January 2009
Funding: $ 0.00
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services Division of Medical Services
PO Box 1437, Slot S401, 700 Main Street
Little Rock, AR 72203-1437

Status: On 7/30/2008, Arkansas submitted a request for a three-year extension for the demonstration, which is pending. As of 9/30/2008, 60,665 individuals received family planning services through this demonstration.

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

Arkansas TEFRA-like Demonstration

Project No: 11-W-00163/6
Project Officer: Mark Pahl
Period: October 2002 to December 2010
Funding: $ 0.00
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services Division of Medical Services
PO Box 1437, Slot S401, 700 Main Street
Little Rock, AR 72203-1437

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

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

ARKids B

Project No: 11-W-00115/6
Project Officer: Mark Pahl
Period: August 1997 to January 2009
Funding: $ 0.00
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project
Awardee: Arkansas, Department of Health and Human Services Division of Medical Services
PO Box 1437, Slot S401, 700 Main Street
Little Rock, AR 72203-1437

Status: On September 19, 2007 the State of Arkansas requested a three year extension of the ARKids B demonstration. If approved the extension will run through September 30, 2011. Currently the demonstration is operating under temporary extensions while the renewal is being considered.

Description: The ARKids B demonstration provides coverage for uninsured children through age 18 with family income at or below 200% FPL. Individuals can choose between the State's traditional Medicaid program and the ARKids B program. Arkids B offers a less comprehensive benefit package and requires co-

payments. The demonstration utilizes the same provider system as the traditional Arkansas Medicaid program and operates as a primary care case management model. The objectives of the demonstration are to integrate uninsured children into the health care delivery system and to provide benefits comparable to the State Employees and State Teachers Insurance Program. Funding through the program is provided through State appropriations and title XXI matching funds are claimed for enrollees who are not eligible for traditional Medicaid. ■

Autism Spectrum Disorders (ASD) Services Contract

Project No: HHSM-500-2006-00007I/09
Project Officer: Ellen Blackwell
Period: September 2008 to September 2010
Funding: $385,801.00
Principal Investigator: Denise Juliano-Bult
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: The contractor selected for the ASD project in IMPAQ, International. Efforts are presently underway on Task 1 and Optional Task A, the Environmental Scan, and the Report on States' Services to Individuals with ASD. The contractor has submitted a Final Workplan that spans the full task order; the tasks build on one another. The Environmental Scan involves an examination of empirical literature to determine which ASD-related services have been shown to be safe and effective for three key groups: children, youth, and adults. It will also assess how evidence based practices map to Medicaid services with regard to provider types/qualifications, service settings, and the amount/duration of services and supports. Interventions will be ranked according to an ordinal scale and categorized into two groups – descriptive and analysis reports. This portion of the contract is already in progress. Regarding Optional Task A, the contractor will analyze ASD-related services and supports in nine States, creating a template for future efforts on a national scale to assess the "state" of ASD services and supports. Program, budget, and other structures will be included in this snapshot of how ASD services and supports are delivered in various States. It is expected that both individual data on the selected States, and the future potential to track data in certain areas for all States, will provide helpful information for policymakers regarding current ASD services, and how ASD services and supports trends may change over time.

Description: This purpose of this task order is to obtain information about services and supports to individuals with ASD, and their families. The Centers for Medicare and Medicaid Services (CMS), request proposals addressing the completion of required Tasks and Optional Tasks that include an environmental scan, assessment of State services, design of model programs, development of an ASD Web portal, meetings, and production of various reports. The task order will help CMS gain valuable information regarding the evidence-based nature of services and supports to individuals with ASD, assess State systems delivery and gaps in services to people with ASD, develop model programs for children and adults with ASD, and create an ASD information portal. It is expected that the first Task, the environmental scan, will be completed in Year One, Optional tasks may be awarded in future fiscal years as funding becomes available. Each Task is expected to be completed in a one year period; thus, the task order could range from 1 year to 4 years, dependant on the number of Optional tasks chosen by CMS. The Final Report and Final Meeting will pertain to all Tasks completed by the contractor. ■

BadgerCare Demonstration

Project No: 11-W-00125/05
Project Officer: Wanda Pigatt-canty
Period: January 1999 to March 2010
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Demonstration
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: On July 8, 2008, the State submitted an amendment request to make changes to demonstration populations, reduce the number of waiver authorities, and eliminate title XXI expenditure authority for parents' coverage. CMS is working with the State to finalize the requested amendment.

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

Basic Medicaid for Able-Bodied Adults

Project No: 11-W-00181/08
Project Officer: Kelly Heilman
Period: January 2004 to January 2009
Funding: $ 0.00
Principal Investigator: Duane Preshinger
Award: Waiver-Only Project
Awardee: Montana Department of Public Health and Human Services
P.O. Box 4210, 111 North Sanders
Helena, MT 59604-4210

Status: As of July 31, 2008, 7,403 individuals were enrolled in the demonstration. Montana has submitted a proposal to extend and significantly revise the demonstration, which is under review.

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

Bedford Ride Program

Project No: 1C0CMS030271/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $ 66,812.00
Principal Investigator: Brenda Lipscomb
Award: Grant
Awardee: Central Virgina Area Agency on Aging, Inc.
3024 Forest Hills Circle
Lynchburg, VA 24501

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: This project will provide non-emergency medical transportation for Bedford City and County citizens. The transportation will include trips to and from dialysis treatments, cancer treatments, and for preventative medical diagnosis. ■

Beneficiary Selection in the Medicare Prescription Drug Program

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

Status: A draft paper is under review for publication.

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

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

Project No: 500-00-0033/10
Project Officer: Noemi Rudolph
Period: September 2005 to April 2009
Funding: $1,530,214.00
Principal Investigator: Leslie Foster
Mary Laschober
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The First Annual Report was submitted to CMS that discussed the findings from a state survey and the first round of stakeholder interviews and focus groups. Case study site visits were completed and a case study report has been submitted to CMS. A draft final report has been submitted to CMS and is under review.

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

Bi-State Primary Care Association

Project No: 1C0CMS030267/01
Project Officer: Jessica Kahn
Period: July 2008 to December 2009
Funding: $310,479.00
Principal Investigator: Lori Real
Award: Grant
Awardee: Bi-State Primary Care Association
3 South StreetConcord, NH 03301
Concord, NH 03301

Status: Funds were awarded and accepted by the grantee. The first semi-annual progress report is due January 30, 2009. The first financial report is due Sept. 30, 2009.

Description: The object of this grant is to provide emergency funding to address the health center's provision of medical services to indigent patients beyond budgeted revenue. ■

Cancer Diagnosis and Treatment Among Medicare Managed Care Enrollees

Project No: ORDI-06-100106
Project Officer: Gerald Riley
Period: October 2006 to October 2008
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: An article was published in "Medical Care" in October of 2008. The project is now complete.

Description: There is considerable policy interest in comparing patterns of care provided in the managed care and fee-for-service (FFS) sectors. Previous research has shown that patterns of cancer diagnosis and treatment often vary between the managed care and fee-for-service (FFS) sectors within the Medicare program. This study updates and extends earlier work using the Surveillance, Epidemiology, and End Results (SEER)-Medicare linked database, which combines tumor registry data with

Medicare enrollment and claims data. The study covers the years 1998-2002 and includes elderly Medicare beneficiaries diagnosed with breast, prostate, and colorectal cancer. The analysis focuses on percents of cases diagnosed at early and late stages and, among early stage cases, managed care-FFS differences in treatment patterns. Plan variation in diagnosis and treatment patterns will be addressed. ■

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

Project No: HHSM-500-2007-00022C
Project Officer: Siddhartha Mazumdar
Period: August 2007 to August 2011
Funding: $ 29,400.00
Principal Investigator: Robert Godbout
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

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

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

Childless Adults Aged 50-64

Project No: 11-W-00139/03
Project Officer: Camille Dobson
Period: March 2002 to September 2011
Funding: $ 0.00
Principal Investigator: Robert Maruca
Award: Waiver-Only Project
Awardee: District of Columbia, Department of Health
825 North Capitol Street, NE, Suite 5135
Washington, DC 20002

Status: On January 31, 2008, the demonstration was granted an extension of three-years and eight-months, through September 30, 2011, to synchronize Demonstration Years with the Federal Fiscal Year.

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

Chronic Condition Warehouse Contract (CCW)

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

Status: The project is underway.

Description: This contractor will operate the Chronic Condition Warehouse database and develop a process to disseminate data to health services researchers studying ways to improve the quality and reduce the cost of care provided to chronically ill Medicare beneficiaries. ■

Clilnical Logic of Episode Groupers

Project No: HHSM-500-2006-00008I/02
Project Officer: Fred Thomas
Period: August 2007 to June 2009
Funding: $499,503.00
Principal Investigator: David Kennell
Award: Task Order (XRAD)

Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The scedule of delieverables has been changed and the period of performance is extended from 08/26/08 through 06/26/09.

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

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

Project No: HHSM-500-2005-00029I/14
Project Officer: Jody Blatt
Period: September 2008 to September 2011
Funding: $149,993.00
Principal Investigator: Michael Trisolini
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The project is underway.

Description: This task order provides ongoing support for the collection and management of clinical quality measure data for the Medicare Care Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This demonstration began operations on July 1, 2007 and will continue through June 30, 2010. Data collection activities will continue for another year after that date. Currently Research Triangle Institute International (RTI) and its subcontractor, the Iowa Foundation for Medical Care (IFMS) are performing related tasks under Contract 500-00-0024, Task Order #13. ■

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

Project No: CMS-ORDI-2008-0001
Project Officer: Gerald Riley
Period: October 2006 to October 2008
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: Findings were published in the October 2008 issue of Medical Care. Citation: Riley G.F., Warren J.L., Potosky, A.L., Klabunde, C.N., Harlan, L.C., and Osswald, M.B. Comparison of Cancer Diagnosis and Treatment in Medicare Fee-for-Service and Managed Care Plans. Medical Care, vol. 46, issue 10, pp. 1108-1115, October 2008. Objective: To compare the Medicare managed care (MC) and fee-for-service (FFS) sectors on stage at diagnosis and treatment patterns for prostate, female breast, and colorectal cancers, and to examine patterns across MC plans. Data: Surveillance, Epidemiology, and End Results - Medicare linked data. Methods: Among cases diagnosed at ages 65-79 between 1998 and 2002, we selected all MC enrollees (n=42,467) and beneficiaries in FFS (n=82,998) who resided in the same counties. MC and FFS samples were compared using logistic regression, adjusting for demographic, geographic, and clinical covariates. Results: The percentage of late stage cases was similar in MC and FFS for prostate and colorectal cancers; there were slightly fewer late stage breast cancer cases in MC (7.3 percent vs. 8.5 percent, $p < 0.001$). Within MC, radical prostatectomy was performed less frequently for clinically localized prostate cancer (18.3 percent vs. 22.4 percent, $p < 0.0001$), and twelve or more lymph nodes were examined less often for resected colon cancer cases (40.9 percent vs. 43.0 percent, $p < 0.05$). Treatment patterns for early stage breast cancer were similar in MC and FFS. Analyses of treatment patterns at the individual plan level revealed significant variation among plans,

as well as within the FFS sector, for all three types of cancer. Conclusions: On average there are few significant differences in cancer diagnosis and treatment between MC and FFS. Such comparisons however mask the wide variability among managed care plans, as well as FFS providers. Observed variation in patterns of care may be related to patient selection, but can potentially lead to outcome differences. These findings support the need for quality measures to evaluate plan practices and performance.

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

Consumer-Directed Chronic Outpatient Services Demonstration

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

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

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

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

Project No: HHSM-500-2006-00005I/05
Project Officer: Debbie Vanhoven
Period: September 2007 to
September 2008
Funding: $123,276.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale,VA 22003

Status: A contract was awarded to Actuarial Research Corporation (ARC) on September 21, 2007 and expired September 20, 2008. ARC submitted a final waiver cost estimate package to CMS in December 2007. OMB subsequently approved the demonstration in February 2008.

Description: The Centers for Medicare & Medicaid Services (CMS) plans to implement a demonstration

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

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

Project No: 95-C-91318/09
Project Officer: Ronald Lambert
Period: August 2002 to July 2008
Funding: $ 0.00
Principal Investigator: Beth Hale
Award: Cooperative Agreement
Awardee: Hospice of the Valley
3238 North 16th Street
Phoenix, AZ 85016

Status: Hospice of the Valley offered an urban case management program to Medicare beneficiaries in Maricopa County, Arizona, with significant chronic illness. Targeting beneficiaries with various chronic conditions, the program focused on providing and coordinating chronic and palliative care. The demonstration ended for this site on July 31, 2008. The site submitted a final report to CMS in October 2008.

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

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

Project No: 95-C-91351/05
Project Officer: John Pilotte
Period: June 2002 to May 2008
Funding: $ 82,350.00
Principal Investigator: Ken Yale
Award: Cooperative Agreement
Awardee: CorSolutions Medical, Inc.
9500 W. Bryn Mawr Avenue
Rosemont, IL 60018

Status: The disease management program targets beneficiaries in the Greater Houston, Texas Metropolitan Area with high-risk congestive heart failure. The site concluded operations as of May 2008.

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

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

Project No: 95-C-91340/07
Project Officer: Siddhartha Mazumdar
Period: April 2002 to March 2010
Funding: $ 50,000.00
Principal Investigator: Nancy Halford
Award: Cooperative Agreement

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

Status: Mercy Medical Center of Mason City, Iowa, has implemented a rural case management program targeting beneficiaries in northern Iowa with various chronic conditions. The site is currently enrolling beneficiaries and providing coordinated care services. The demonstration was extended for two additional years in order to further test the cost effectiveness of the case and disease management intervention.

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

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

Project No: 95-C-91315/5
Project Officer: Dennis Nugent
Period: April 2002 to March 2008
Funding: $149,943.00
Principal Investigator: Cheryl Schraeder
Award: Cooperative Ageement
Awardee: Carle Foundation Hospital
307 East Oak #3, PO Box 718
Mahomet, IL 61853

Status: The Carle Foundation Hospital of Mahomet, Illinois implemented a rural case management program targeting beneficiaries with various chronic conditions in eastern Illinois. The project ended March 31, 2008.

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

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

Project No: 95-C-91314/01
Project Officer: Siddhartha Mazumdar
Period: April 2002 to March 2008
Funding: $138,720.00
Principal Investigator: John LaCasse
Award: Cooperative Ageement
Awardee: Medical Care Development
11 Parkwood Drive
Augusta, ME 04330

Status: Medical Care Development of Augusta, Maine, implemented a rural disease management program targeting beneficiaries in Maine with congestive heart failure or post-acute myocardial infarction. The site's participation in the demonstration has ended after six years.

Description: This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated

Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral. ■

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

Project No: 95-C-91345/7
Project Officer: Ronald Lambert
Period: August 2002 to July 2008
Funding: $150,000.00
Principal Investigator: John Lynch
Award: Cooperative Agreement
Awardee: Washington University Physician Network
660 South Euclid Avenue, Campus Box 8066
St. Louis, MO 63110

Status: Washington University of St. Louis, Missouri, has operated an urban case management program targeting beneficiaries in St. Louis with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in August 2002. The demonstration ended for this site on July 31, 2008. The site submitted a final report in October 2008.

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

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

Project No: 95-C-91357/2
Project Officer: Dennis Nugent
Period: June 2002 to May 2008
Funding: $150,000.00
Principal Investigator: Patricia Mulvey
Award: Cooperative Agreement
Awardee: The Jewish Home and Hospital for the Aged
120 West 106th Street
New York, NY 10025

Status: The Medicare Coordinated Care Demonstration conducted at the Jewish Home and Hospital for the Aged ended on May 31, 2008.

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

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

Project No: 95-C-91352/02
Project Officer: John Pilotte
Cynthia Mason
Period: July 2002 to
July 2008
Funding: $150,000.00
Principal Investigator: Jane Murray
Award: Cooperative Ageement
Awardee: QMED
25 Christopher Way
Eatontown, NJ 07724

Status: QMED, Inc., Eatontown, New Jersey, has implemented a disease management program targeting beneficiaries in northern California with coronary artery disease. The site concluded operations as of July 2008.

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

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

Project No: 95-C-91360/03
Project Officer: Cynthia Mason
Period: April 2002 to
March 2010
Funding: $ 0.00
Principal Investigator: Kenneth Coburn
Award: Cooperative Ageement
Awardee: Health Quality Partners
875 N. Easton Road
Doylestown, PA 18901

Status: Health Quality Partners of Doylestown, Pennsylvania, has implemented an urban and rural disease management program targeting beneficiaries in eastern Pennsylvania with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in April 2002. The demonstration was extended for two additional years in order to further test the cost effectiveness of Health Quality Partners' coordinated care interventions.

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

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

Project No: 95-C-91319/03
Project Officer: Cynthia Mason
Period: April 2002 to March 2008
Funding: $ 75,448.00
Principal Investigator: Michael Matthews
Award: Cooperative Ageement
Awardee: CenVaNet
2201 W. Broad Street, Suite 202
Richmond,VA 23220

Status: CenVaNet, Incorporated of Richmond, Virginia, implemented an urban case management program targeting beneficiaries with various chronic conditions in the metropolitan Richmond area. The site began enrolling beneficiaries and providing coordinated care services in April 2002. The project ended on March 31, 2008.

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

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

Project No: 95-C-91362/08
Project Officer: Siddhartha Mazumdar
Period: June 2002 to May 2008
Funding: $ 0.00
Principal Investigator: David Kuper
Award: Cooperative Ageement
Awardee: Avera McKennan Hospital
800 East 21st St
Sioux Falls, SD 57105

Status: Avera McKennan Hospital of Sioux Falls, South Dakota, has implemented a rural disease management program targeting beneficiaries in South Dakota, Iowa, and Minnesota. Avera McKennan has ceased participation in the demonstration effective May 31, 2008.

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

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

Project No: 1R0CMS300065
Project Officer: Susie Butler
Period: March 2006 to February 2008
Funding: $156,200.00
Principal Investigator: Kristen Keifer
Award: Grant
Awardee: National Council on the Aging
300 D St, NW
Washington, DC 20024

Status: The project was funded for one year and it was completed in 2008.

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

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

Project No: ORDI-05-0009
Project Officer: Penny Mohr
Period: December 2003 to June 2008
Funding: $ 0.00
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The research protocol had been completed, which included a plan for analyzing the cost-effectiveness of more frequent hemodialysis to the Medicare Program. Randomization of study subjects began and study results were expected to be available by June 2010. Unfortunately, the budget was cut substantially for collection of cost data. This dramatically reduced the likelihood that we could get usable data so we had shut the project down. More information on the trials can be found at: http://www.niddk.nih.gov/patient/hemodialysis/hemodialysis.htm.

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

Cost-Effectiveness of Early Preventive Care for Children in Medicaid

Project No: ORDI-IM-084
Project Officer: Paul Boben
Period: June 2000 to December 2009
Funding: $ 0.00
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The project is ongoing.

Description: This project will feature a cost-benefit analysis of primary and preventive care for children up to age 2. Medicaid claims data from the State Medicaid Research Files data base will be used to compare costs of care for children receiving the recommended battery of well-child visits versus those that do not. The benchmark for standard care will be the American Academy of Pediatrics' (AAP) recommended series of well-baby visits and immunizations. This study follows work by Hakim and Bye (Pediatrics, 2001) that showed an association between compliance with the AAP schedule and reduced risk of avoidable hospitalization. ■

Data Collection for the Second Generation S/HMO Demonstration

Project No: 500-01-0025/03
Project Officer: Dennis Nugent
Period: September 2004 to October 2008
Funding: $3,224,421.00
Principal Investigator: Todd Ensor
Award: Task Order (ADDSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

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

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

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

Project No: 95-W-00086/01
Project Officer: Juliana Tiongson
Period: January 2001 to December 2011
Funding: $ 0.00
Principal Investigator: Kristine Ragaglia
Award: Waiver-Only Project
Awardee: Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Status: The first year of arbitrations were completed. Cases will be filed for the second year of arbitrations beginning in January. Although two of the three states requested that the demonstration be extended to include Federal claims year for the year 2008, this request was denied by CMS and the project will end once all claims through 2007 have been ajudicated.

Description: CMS is conducting a pilot program with the States of Connecticut, Massachusetts, and New York that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were originally submitted to and paid by the Medicaid agencies. This sampling will be used in lieu of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This process will eliminate the need for the home health agencies (HHA) to assemble, copy, and submit huge numbers of medical records, as well as the need for the regional home health intermediary (RHHI) to review every case. The demonstration will consist of two components: (1) an educational initiative to improve the ability of all parties to make appropriate coverage recommendations for crossover claims and (2) a statistically valid sampling methodology to be applied in settlement of claims paid by Medicaid for which the State believes may have potential to also be covered by Medicare. The demonstration in Connecticut covers HHA claims for Fiscal Years 2001 through 2007. ■

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

Project No: 95-W-00084/02
Project Officer: Juliana Tiongson
Period: January 2002 to December 2011
Funding: $ 0.00
Principal Investigator: Jeff Flora
Award: Waiver-Only Project
Awardee: Office of Medicaid Management, New York Department of Health, Empire State Plaza
Corning Tower, Room 1466
Albany, NY 12237

Status: The demonstration in New York covers Fiscal Years 2000 through 2007. The first year of arbitration which represents the final level of appeal was completed in November 2008. New York has received initial settlements on all of the out years through 2005. Final settlements are pending on all years except 2001. A second year of arbitration is scheduled to begin in January 2009.

Description: CMS is conducting a pilot program with the States of Connecticut, Massachusetts, and New York that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dually eligible beneficiaries that were originally submitted to and paid by the Medicaid agencies. This sampling will be used in lieu of individually gathering Medicare claims from home health agencies for every dually eligible Medicaid claim the State has possibly paid in error. This process will eliminate the need for the home health agencies (HHA) to assemble, copy, and submit huge numbers of medical records, as well as the need for the regional home health intermediary (RHHI) to review every case. The demonstration consists of two components: (1) an educational initiative to improve the ability of all parties to make appropriate coverage recommendations for crossover claims and (2) a statistically valid sampling methodology to be applied in settlement of claims paid by Medicaid for which the State believes may have a potential to also be covered by Medicare. ■

Demonstration to Maintain Independence and Employment - District of Columbia

Project No: 11-P-91421/03
Project Officer: Claudia Brown
Stephen Hrybyk
Period: January 2002 to December 2008
Funding: $12,599,022.00
Principal Investigator: Robert Cosby, M.D.
Award: Grant
Awardee: District of Columbia, Department of Health, Medical Assistance Administration
Suite 5135, N. Capitol St., NE
Washington, DC 20002

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

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration. The demonstration provides highly active antiretroviral drug therapy (HAART) to 420 persons who have early HIV infection, and are not yet disabled under SSA criteria. The demonstration also provides the full range of Medicaid benefits to participants. Persons being served are primarily African American (76 percent). Fifty-nine percent are between the ages of 25 and 44, while 37 percente are 45-64. The program has spent $4 million in service claims, at an average of $8,635 per enrollee. Eighty-three percent of the expenditures have been for prescription drugs. ■

Demonstration to Maintain Independence and Employment - Kansas

Project No: 11-P-92389/07-01
Project Officer: Claudia Brown
Period: April 2006 to September 2009
Funding: $5,000,000.00
Principal Investigator: Mary Ellen O'Brien Wright
Award: Grant

Awardee: Kansas, Department of Social and Rehabilitation Services
915 Harrison St. 6th Floor North
Topeka, KS 66612-1570

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

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration. This demonstration will provide State Medicaid and other health and employment support services as wraparound coverage to a targeted 200 people with health insurance through the Kansas high-risk pool, also known as the Kansas Health Insurance Association (KHIA). People in the high-risk pool experience multiple severe conditions for which they have been unable to obtain employer-sponsored coverage or reasonably priced private coverage. They are ineligible for either Medicaid or Medicare and about one-third of participants are employed. The goals of the project are to improve the health and quality of life of individuals in the intervention group and to demonstrate that, compared to a carefully matched control group of 200 individuals also in the pool, they maintain a higher rate of employment and are less likely to become eligible for any form of Social Security disability benefits or other forms of public assistance. ■

Demonstration to Maintain Independence and Employment - Minnesota

Project No: 11-P-92387/05-01
Project Officer: Claudia Brown
Period: November 2006 to September 2009
Funding: $5,000,000.00
Principal Investigator: MaryAlice Mowry
Award: Grant
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0998

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

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration. The Department of Human Services is using this demonstration as an opportunity to build on its history of creating public-private partnerships to better serve the needs of Minnesotans coping with mental illness. It serves a targeted 1,500 to 1,800 employed people diagnosed with serious mental illness in Hennepin, Ramsey, and St. Louis Counties. Employment-related services include ongoing contact with a project navigator, a peer support program, and employment counseling. Medical services and employment interventions will be delivered through a network of partnering health plans and community mental health service providers. ■

Demonstration to Maintain Independence and Employment - Texas

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

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

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration. Texas proposed to redesign their project to use a public / private partnership in the provision of comprehensive behavioral health benefits to working

adults at risk of becoming disabled in the Houston area. The insurance benefit will augment existing employer sponsored coverage and may provide full coverage for working individuals who do not have access to employer sponsored coverage (i.e. self-employed). It is anticipated that many people displaced by hurricane Katrina who are currently residing in the Houston area will take advantage of this program. ■

Demonstration-Based Review of Physician Practice Expense Geographic Adjustment Data

Project No: 500-00-0024/16
Project Officer: Jesse Levy
Period: July 2004 to June 2009
Funding: $613,917.00
Principal Investigator: Gregory Pope
Steven Zuckerman
Award: Grant
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The report that led to the Report to Congress was delivered in March 2006. It is located here: http://www.cms.hhs.gov/Reports/downloads/Pope03-06.pdf The GPCI geographic configuration report has been completed. The title of the report is "Payment Areas for Medicare Physician Services: Selected Alternatives. It is located here: http://www.cms.hhs.gov/Reports/downloads/Adamache_Final_March_2008.pdf The contract was modified to provide a no-cost extension to June 30, 2009. Task Order (RADSTO)

Description: This contract supported a Report to Congress.The purpose is two-fold. The first is to assess the validity of these geographic adjustment methods by convening groups of interested parties in two localities, as described in the law, to discuss the availability of data in these localities and nationally. The second is to assess the generalizability of the data to assist in the creation of geographic indices for practice expenses for use with the Medicare fee schedule for physician services. Work has also been performed supporting GPCI geographic configuration analysis. This work has also been completed ■

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

Project No: HHSM-500-2006-00008I/03
Project Officer: William Buczko
Period: July 2008 to June 2011
Funding: $879,696.00
Principal Investigator: David Kennell
Barbara Gage
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project kickoff meeting was held on July 18, 2008. The outline for the Report to Congress has been approved by CMS. The Report to Congress will be due to CMS in December, 2008. The research design for additional studies will be due in early 2009. The additional studies will begin during 2009.

Description: Section 114 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173) states that the Secretary of Health and Human Services shall conduct a study on the establishment of national long-term care hospital and facility and patient criteria for determining medical necessity, appropriateness of admission, and continued stay and discharge from long-term care hospitals. The Secretary shall submit a report on the results of this study to Congress together with recommendations for legislation and administrative action, including timelines for implementation of patient criteria or other appropriate action by June 30, 2009. The contractor will describe any additional research studies that are needed to answer the research/policy questions raised in the previous section. The research areas to be considered can cover Medicare policy areas such as facility classification/conditions of participation, payment systems (including patient classification issues and "bundled" models across individual payment systems), quality of care and other related topics. Innovative approaches to addressing the key research questions and policy concerns are encouraged. The contractor will provide a discussion of the rationale and methodology proposed for each study. A full research design for additional analyses will be presented after the Report to Congress has been submitted. Data analyses for these analyses will be performed in project years 2 and 3. The contractor shall address (but is not limited to examination of) the following research questions: • What facility/patient criteria can be used to uniquely define LTCHs and patients that are appropriate for care in LTCHs? • What facility criteria are needed to ensure appropriate

provision of care in LTCHs? • What criteria are needed to determine appropriateness of admissions, discharges, and treatment modalities, medical complexity, quality of care and improvement potential for patients commonly treated in LTCHs? • What criteria/reforms are needed to ensure parity in Medicare payments, access to care and quality of care between patients treated in LTCHs and patients with similar conditions treated in other settings? ■

Developing Outpatient Therapy Payment Alternatives

Project No: HHSM-500-2005-00029I/12
Project Officer: David Bott
Period: January 2008 to January 2013
Funding: $2,923,940.00
Principal Investigator: Ed Drozd
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Hear are some current project milestones: (1) A Technical Expert Panel was convened to obtain expert and stakeholder input on the feasibility and value of proposed measures of therapy related information. (2) A Special Open Door Forum was held. This Special ODF introduced to a broad audience the Developing Outpatient Therapy Payment Alternatives (DOTPA) project with a special emphasis on how data will be collected for this project and how facilities, practices and individual providers may become involved and contribute to this ground-breaking research. (3) A variety of meetings with stakeholders have been conducted to obtain input, disseminate information about the project, and to lay the foundation for recruiting provider participants for the data collection activities. (4) Development of the data collection instrument is ongoing.

Description: CMS envisions a new method of paying for outpatient therapy services that is based on classifying individual beneficiary's needs and the effectiveness of therapy services, for example diagnostic category, functional status, health status. CMS does not currently collect the appropriate data elements, and therefore cannot evaluate or implement this type of approach. However, the therapy community has been working on these issues and may have data relevant to CMS's intended goals. This project will identify, collect and use therapy related information that is tied to beneficiary need and the effectiveness of outpatient therapy service. The ultimate goal of the task order is to develop payment method alternatives to the current cap on outpatient therapy services. The 5-year contract has three main tasks, 1) identify and collect beneficiary level measures of health and functional status not available to CMS currently through claims; 2) provide high-level analysis of the annual utilization and expenditures for outpatient therapy services to enable CMS to monitor changes; and 3) use the collected beneficiary level data to conduct and report analyses that provide the bases for payment method alternatives. ■

Development and Validation of MDS 3.0

Project No: 500-00-0027/02
Project Officer: Thomas Dudley
Period: April 2003 to May 2008
Funding: $4,039,564.00
Principal Investigator: Debra Saliba
Award: Task Order (RADSTO)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: This contract ended 5/31/2008.

Description: The purpose of this procurement is to refine and validate Version 3.0 of the MDS. The goal of the refinement is to produce a valid instrument that reduces user burden; is more clinically relevant, while still achieving the federal payment mandates and quality initiatives; is more intuitive for users; includes better use of standard assessment scales; use of common language from health information and HIPPA standards; assesses resident quality of life; and, where possible, is more resident-centered. Prior to drafting MDS 3.0, CMS convened a number of clinical meetings with industry experts to identify existing scales, indices, and measurement tools that are relevant to the nursing home setting. Information obtained by the clinical meetings will be shared with the offeror to help create a revised MDS tool. The goal is to create an instrument which is fluid and can adapt to various resident populations without being redundant or burdensome to facilities specializing in specific populations. Guidelines for each item must be developed that clarify the intent, definition, and process for collecting and coding for each data item. This material must be suitable for software with wizards and other intuitive data accumulation methods. Providers and stakeholders must be involved throughout the refinement and validation process. In addition, for

each data item considered for the MDS 3.0, the specific uses of the element must be identified resource utilization group item, quality measure, quality indicator, resident assessment protocols (RAP), etc. as well as specifying implications of any revised item to the RAPs, the Prospective Payment System (PPS), and State-specific case mix systems. Special attention should also be paid to how the instrument can be modified to suit a quarterly assessment form and how the final instrument fits with the Medicare Payment Assessment Form (MPAF). Payment items considered for revision cannot be changed unless a direct crosswalk between the revised item and the old payment item is available and must be validated in the field testing of the instrument. The offeror will take this information into consideration when redesigning the tool. In designing the analytic plan and implementing the validation study, it was recommended that the contractor work with an organization knowledgeable about the MDS instrument, its history and current uses. The contractor is working with the State Quality Improvement Organizations to recruit nurses within each state to conduct the onsite validation and information collection. This approach was particularly effective in minimizing travel expenditures and expediting the onsite data collection. CMS recognizes that this is only one approach and is just discussed as one possible option in conducting the validation. Other options are also welcome but should be described in detail as part of the work plan. ■

Development of a National MAX Enrollee File

Project No: 500-02-0006/06
Project Officer: David Baugh
Period: September 2005 to July 2008
Funding: $109,981.00
Principal Investigator: Celia H. Dahlman
Award: Delivery Order
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

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

Description: This project has developed the design for a National Person Summary File (NPIF) for MAX. The contractor developed an algorithm to unduplicate individuals across States and over time, using data elements such as IDs - Medicaid and Medicare, Social Security number, date of birth and gender. In addition, the contractor analyzed the potential for both type 1 and type 2 errors in the unduplication process. There are a number of reasons for mismatches, including one enrollee reporting another person's SSN as their own, missing or erroneous SSNs and reporting of Individual Tax Identification Numbers-ITINs - as SSNs. The project also accomplished several other goals, including: (1) how to use supplemental files provided by selected state Medicaid agencies to unduplicate Medicaid enrollees, (2) design the record layout for the NPIF, (3) determine what the unique identifier should be in the NPIF, and (4) determine what the records should be in the NPIF (e.g. one record per unique person or multiple records per unique person with linking data). This task order ended July 31, 2008. This completed work is now being used in another task order to develop a prototype of the NPIF. The eventual aim in the process of creating this NPIF file for MAX is to: (1) develop more accurate estimates of national Medicaid enrollment, (2) assist data users who need to conduct research on more than one State, particularly those who want to track a unique person's Medicaid enrollment and utilization across states, and (3) assist users that need to build longitudinal cohorts of enrollees. ■

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

Project No: 1HOCMS030309/01
Project Officer: Richard Bragg
Period: September 2008 to September 2010
Funding: $225,000.00
Principal Investigator: Barbara Sterry
Award: Grant
Awardee: Nova Southeastern University, College of Pharmacy
3301 College Avenue
Fort Lauderdale, FL 33314

Status: The is a new grant under the Hispanic Health Services Research Grant.

Description: Type 2 diabetes is a national epidemic affecting an estimated 21 million individuals. The prevalence of diabetes among the Latina population is 1.7 times that of the majority population. The rapid growth

of the Latino population suggests that the prevalence of diabetes will continue to rise in the next decades. The total annual economic cost of diabetes in 2007 was estimated to be $174 billion, with $27 billion sepnt on diabetes care, $58 billion for diabetes complications, and $31 billion for excess general medical costs. The primary objective of the Diabetes Literacy and Self-Efficacy Screening and Training Project (Diabetes LASST) is to test the efficacy of a community-based intervention to improve self-management, perceived self-efficacy, and clinical outcomes for diabetes. The secondary objective is to screen diabetics and a partnered family member who is at risk for diabetes and chronic kidney disease as part of the care for diabetes. The specific aims are to: 1) Test the efficacy of a Pharmacist-Centered Assessment and Reinforcement of Diabetes Self-efficiacy (PARDS) intervention at improving diabetes health literacy in Latino diabetics and their family members. 2) Promote positive changes in exercise and diet as measured by information in patient logs and follow-up sessions with a pharmacist. 3)Test the efficacy of PARDS at improving perceived self-efficacy and cllinical outcmes for Latino diabetic participants. ■

Diamond State Health Plan

Project No: 11-W-00036/03
Project Officer: Diane Gerrits
Edward Hutton
Period: May 1995 to
December 2009
Funding: $ 0.00
Principal Investigator: Harry Hill
Award: Waiver-Only Project
Awardee: Delaware Health and Social Services (New Castle)
P. O. Box 906, Lewis Building
New Castle, DE 19720

Status: The Demonstration was approved for a three-year extension on December 21, 2006. The State is currently considering additional cost containment measures to ensure that their budget neutrality limit is not exceeded. Letter of intent to renew the demonstration received on November 25, 2008.

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

Econometric Forecasting and Economic Services

Project No: 500-2006-00037G (GS-10F-0318K)
Project Officer: Bridget Dickensheets
Period: April 2006 to
April 2008
Funding: $1,899,711.00
Principal Investigator: John Larson
Award: Contract
Awardee: Global Insight Incorporated
1850 M Street NW, Suite 1100
Washington, DC 20036

Status: This contract continues year-to-year since it provides basic support for our actuarial estimates used in operating the Medicare Program. The contractor has also constructed forecasts of CMS's input price indexes on a quarterly basis and has provided assistance with OACT work on the President's Budget and Trustees Report. Option Year II was exercised and provided funding dollars in the amount of $487,087 for the period April 18, 2008 through April 17, 2009.

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

Educational Intervention with HIV Infected Patients: A Randomized Study

Project No: 25-P-92351-4/02
Project Officer: Richard Bragg
Period: September 2004 to November 2007
Funding: $249,495.00
Principal Investigator: Jose Castro
Award: Grant
Awardee: University of Miami School of Medicine
1800 NW 10th Ave.
Miami, FL 33136

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

Description: This project is a collaborative effort of the University of Miami School of Medicine's AIDS Clinical Research Unit (ACRU), the Miami Drug Abuse & AIDS Research Center, and the Jackson Memorial Hospital HIV/AIDS Clinical Program. The purpose of this project is to implement and evaluate the effectiveness of culturally sensitive, structured educational sessions for Hispanic American HIV-infected patients seen in the outpatient setting using a two-group randomized design. This randomized intervention study will seek to determine whether or not structured educational sessions improve outcomes of HIV infected patients. The sessions will be conducted in the primary language of the participants and will be given by an educator who is fluent or native of that language. The session will be interactive and will include the following: (1) HIV Care Basics, (2) HIV Treatments, and (3) Antiretroviral Therapy Basics. ■

Empirical Analysis of a New Payment System

Project No: 500-00-0032/10
Project Officer: Randy Throndset
Ann Meadow
Period: September 2004 to February 2009
Funding: $1,551,813.00
Principal Investigator: Henry Goldberg
Alan White
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The final analytical report was released on April 30, 2008 (see www.cms.hhs.gov/Reports/downloads/Coleman_Final_April_2008.pdf). It contains results of research and analysis that Abt Associates conducted to address Medicare's information and program administration needs pertaining to the home health prospective payment system implemented in October 2000. Topics include: trends in patient and payment-related data over time; refinements to the original home health prospective payment system case mix model; reducing reliance on the therapy threshold in the case mix model; and how the system can account for costs of caring for long-stay patients and highly variable costs of bundled nonroutine medical supplies. This report also details the analyses and simulations used by CMS in its 2007 case-mix and payment proposals in the Notice of Proposed Rulemaking (CMS-1451-P, Federal Register, May 4, 2007). It also covers in detail subsequent validation analyses and simulations used in the Final Payment Rule (CMS-1451-FC, Federal Register, August 29, 2007).

Description: The project provides evidence about how the Medicare home health benefit is operating under PPS. Information and analysis of various payment adjustments included in the home health PPS are intended to provide a basis for evaluating possible refinement options affecting features of the home health PPS design. The project develops background information to enable agency staff and policymakers to understand agencies' financial performance and patterns of care under PPS for various groups of agencies and patients. Under this contract, Abt Associates also develops and provides technical support for the home health PPS grouper software. ■

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

Project No: 95-W-00187/01
Project Officer: Heather Grimsley
Period: January 2006 to December 2009
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: Fresenius Medical Care North America (FMCNA)
10901 West 120th Street, Suite 200
Broomfield, CO 80021

Status: The organization began enrolling patients January 1, 2006. The total enrollment in all FMCHP

plans as of November 2008 is 538 beneficiaries. In 2008, FMCHP plans are available to beneficiaries with ESRD in select counties in the following States: Alabama, California, Connecticut, Illinois, Massachusetts, Minnesota, New York, Pennsylvania, Rhode Island, Tennessee, and Texas.

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

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

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

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

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

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

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

Status: The organization began enrolling patients on January 1, 2006. The enrollment as of late 2008 was 413. The demonstration has been extended for one more year, until December 31, 2010.

Description: The End-Stage Renal Disease (ESRD) Disease Management Demonstration will increase the opportunity for Medicare beneficiaries with ESRD to

join integrated care management systems. Ordinarily, Medicare beneficiaries with ESRD are prohibited from enrolling in Medicare Advantage plans. This demonstration makes an exception to the rule, allowing MA organizations to partner with dialysis organizations to enroll beneficiaries with ESRD in specified service areas. The dialysis/MA organization must provide all Medicare covered benefits. Organizations serving ESRD patients will receive the same risk-adjusted ESRD capitation payments as for the MA program overall – with separate rates for dialysis, transplant, and post-transplant modalities. The actual payment amount, however, will be reduced by 5 percent, which will be available to the organizations depending on performance on quality measures. CMS has determined 6 dialysis-related indicators on which performance will be assessed. These indicators are adequacy of dialysis, anemia management, serum phosphorous, serum calcium, fistulas, and catheters. These indicators and standards were developed in consultation with participating organizations and with the CMS implementation contractor, Arbor Research Collaborative for Health. ■

Episode Grouper Software Evaluation

Project No: 500-01-0031/02
Project Officer: Fred Thomas
Period: March 2006 to December 2007
Funding: $344,275.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (ADDSTO)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contract has ended.

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

ESRD Measures Support Work

Project No: HHSM-500-2005-000311/01
Project Officer: Thomas Dudley
Period: February 2006 to June 2009
Funding: $3,217,003.00
Principal Investigator: Robert Wolfe
Award: Task Order (MRAD)
Awardee: Arbor Research Collaborative for Health
315 West Huron, Suite 360
Ann Arbor, MI 48103

Status: The contract has been modified to revise the Period of Performance ending date from 06/30/2009 to 9/30/2009

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

Evaluating the BearingPoint Medication Use Measures in a Medicaid Population

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

Status: The project is underway.

Description: This project will test indicators in the Medicaid population and will identify specific medication use behaviors that can be targeted for program interventions with the end result being better quality of care for beneficiaries and cost savings for the program. ■

Evaluation and Support of System Change Grants

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

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

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

Evaluation of Care and Disease Management Under Medicare Advantage

Project No: HHSM-500-2006-00009I/04
Project Officer: Gerald Riley
Period: August 2007 to November 2009
Funding: $495,016.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is ongoing. A Medicare Advantage plan survey was recently completed requesting information on care and disease management programs. Interim findings on the evaluation are expected in early 2009.

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

Evaluation of Competitive Acquisition Program for Part B Drugs

Project No: 500-00-0024/24
Project Officer: Jesse Levy
Period: September 2005 to June 2009
Funding: $1,305,147.00
Principal Investigator: Ed Drozd
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: A report to Congress has been delivered and will be on CMS's web site soon.

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

Evaluation of DRG Classification Systems

Project No: HHSM-500-2005-00028I/01
Project Officer: Philip Cotterill
Period: September 2006 to May 2008
Funding: $487,199.00
Principal Investigator: Curtis Hoy
Award: Task Order (MRAD)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The project was completed.

Description: The project evaluated six different methods to establish the relative weights used in the Medicare IPPS. The questions examined were: How do the relative weights differ across the alternative methodologies? How well does each relative weight methodology explain variation in costs? How accurate are payments using each relative weight methodology and current facility-level adjustments? What are the payment impacts of alternatives to the current methodology for establishing relative weights? Five alternative methods of estimating cost and standardizing for systematic cost differences among hospitals were compared to the current method used by CMS. Two different types of analyses were conducted at both the discharge-level and the hospital-level. One type compared each of the five alternative sets of relative weights to the relative weights constructed using the CMS current relative weight method. These analyses imply no explicit judgments that one set of relative weights is "better" than another; they simply report how the weights or payments would differ under alternative methods. The other type examined the relative payment accuracy of alternative relative weight methods. Different methods imply substantial differences in the relative weights for specific DRGs. However, none of the methods analyzed represent a marked improvement over the method currently used by CMS. Project reports available from RAND are WR-434-CMS, WR-434/1-CMS, and WR-560-CMS. ■

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

Project No: 500-00-0028/02
Project Officer: Diane Frankenfield
Period: September 2003 to December 2009
Funding: $1,628,359.00
Principal Investigator: Sylvia Ramirez
Award: Task Order (RADSTO)
Awardee: Arbor Research Collaborative for Health formerly known as URREA (University Renal Research and Education Association)
315 West Huron, Suite 260
Ann Arbor, MI 48103

Status: The evaluator has prepared preliminary reports describing patient satisfaction, provider satisfaction, reasons for disenrollment, quality of life, clinical outcomes (hospitalization, transplant referral and survival), and cost analyses.

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

Evaluation of Gainsharing Demonstration

Project No: HHSM-500-2005-00029I/03
Project Officer: William Buczko
Period: September 2006 to September 2010
Funding: $2,068,665.00
Principal Investigator: Jerry Cromwell
Award: Contract
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The demonstration began on October 1, 2008. Three sites (Beth Israel NY, Lake Cumberland KY, and Charleston, WV) are participating. The comparison hospitals for each site have been selected. The first wave of site visits is planned for Spring 2009. The baseline data set is being assembled and analysis of baseline characteristics has begun.

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

Evaluation of Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00022I/01
Project Officer: William Buczko
Period: September 2007 to September 2010
Funding: $447,032.00
Principal Investigator: D. Hittle
Award: Task Order (MRAD)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The evaluation kickoff meeting was held in October, 2007. The demonstration began on January 1, 2008. The evaluation contractor has completed the project research design and has formulated site visit protocols. The site survey instrument is currently under PRA review. The survey is scheduled to begin in early 2009. The evaluation contractor has also begun to create data files needed for baseline analyses.

Description: The Home Health Pay for Performance (HHP4P) demonstration is part of a CMS initiative to improve the quality of care furnished to all Medicare beneficiaries receiving care from home health agencies (HHAs). This demonstration will test the "pay for performance" concept in the HHA setting. Under this demonstration, CMS will provide financial incentives to participating HHAs that meet certain standards for providing high quality care. Participation of HHAs in this demonstration will be voluntary. CMS will assess the performance of participating HHAs based on selected measures of quality of care, then make payment awards to those HHAs that either achieve a high level of performance or show exceptional improvement based on those measures. The quality measures include acute care hospitalizations, use of emergent care as well as outcome measures from Outcome and Assessment Information Set (OASIS). This demonstration will select 4 states/stage groups (one from each region of the U.S.) that will be able to provide a representative sample of Medicare HHAs nationwide. In cases where individual states within a region do not have a sufficient number of HHAs to ensure a large enough service population, contiguous, multi-state groups will be selected. Within each state/state group, HHAs electing to participate will be randomly assigned to treatment and control groups. The demonstration will include all Medicare beneficiaries that are in a participating HHA. Some of these beneficiaries will also be eligible for Medicaid. ■

Evaluation of Inpatient PPS Reform

Project No: HHSM-500-2005-00025C
Project Officer: Fred Thomas
Period: August 2005 to April 2008
Funding: $247,048.00
Principal Investigator: Richard Averill
Award: Contract
Awardee: 3M-Health Information Systems
100 Barnes Road
Wallingford, CT 06492

Status: The final report has been submitted for the use in determining inpatient PPS policy. The project is complete.

Description: Section 507 of the MMA requires the Medicare Payment Advisory Commission (MedPAC) and the Secretary of the Department of Health and Human Services (HHS) to study physician-owned cardiac, surgery, and orthopedic specialty hospitals and to report the results of their studies to Congress. The MedPAC study was delivered to Congress on March 8, 2005 and the HHS study was delivered on May 12,

2005. After consideration of the results of the studies, CMS stated that it would assess methodological reforms related to payments for inpatient hospital services. Four reforms were identified by CMS for evaluation in the recommendations section to the Section 507(c) study. This contract will evalute the four reforms: 1) Refine DRGs to more fully capture differences in severity of illness; 2) Base DRG weights on estimated cost of providing care; 3) Base DRG weights on national average of hospitals' relative values in each DRG; and 4) Adjust DRG weights to account for differences in prevalence of high-cost outlier cases. ■

Evaluation of Low Vision Rehabilitation Demonstration (LVRD)

Project No: 500-00-0031/06
Project Officer: Pauline Karikari-Martin
Period: September 2005 to March 2009
Funding: $499,582.00
Principal Investigator: Christine Bishop
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The period of performance for Phase I has been extended to March 31,2009. Phases II, III, and IV have been deleted from the contract.

Description: This Task Order is to conduct an evaluation of the Centers for Medicare and Medicaid Service's (CMS') Low Vision Rehabilitation Demonstration (LVRD). The contractor will be required to design and conduct the evaluation of the demonstration. The evaluation will include qualitative assessments from the the provider and beneficiary perspective. The qualitative assessment will examine issues pertaining to the implementation and operational experiences of the patients and practitioners. Data sources are likely to include site visits and interviews for provider. ■

Evaluation of Medicare Advantage Special Needs Plans

Project No: 500-00-0033/13
Project Officer: Susan Radke
Period: September 2005 to December 2008
Funding: $1,005,970.00
Principal Investigator: Robert Schmitz
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The Evaluation of the Special Needs Plan Report to Congress was cleared and submitted to Congress on October 30, 2008

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

Evaluation of Medicare Health Care Quality Demonstrations - Phase I

Project No: 500-00-0024/22
Project Officer: David Bott
Period: September 2005 to September 2009
Funding: $560,425.00
Principal Investigator: Michael Trisolini
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

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

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

Project No: 500-00-0031/03
Project Officer: Karyn Anderson
William Clark
Period: September 2004 to September 2009
Funding: $674,065.00
Principal Investigator: Christine Bishop
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: The contractor has conducted demonstration site visits and has completed reports on the delivery of integrated care demonstrations and their transition to Medicare Advantage. Phase II is in process.

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

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

Project No: 500-00-0033/06
Project Officer: Ann Meadow
Period: January 2005 to July 2009
Funding: $639,859.00
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor developed a beneficiary survey and conducted site visits and other qualitative data collection. The survey was not administered due to low enrollment in the demonstration. The project plan was modified to address selected research questions, including several that can be answered using information from home health agencies in the demonstration States. Medicare submitted the final Report to Congress in January 2008 (a technical report is available at www.cms.hhs.gov/Reports/downloads/homebound.pdf). The Secretary did not recommend program policy changes, noting that "the complex set of barriers to enrolling beneficiaries . . . are an indication that successful adoption of the eligibility change envisioned in the legislation faces serious impediments." Information from qualitative data collection and the home health agency survey indicated that barriers included the extensive criteria for enrollment laid out in the legislation, concerns on the part of providers that financing might be inadequate, low interest on the part of beneficiaries in changing their care arrangements, and others. Currently the project is using secondary data sources to conduct additional data analysis on utilization characteristics of the target population.

Description: This project supports a congressionally mandated evaluation of a demonstration required under the 2003 Medicare Modernization Act. Section 702, "Demonstration Project to Clarify the Definition of Homebound," requires the Secretary of Health and

Human Services to conduct a 2-year demonstration to test the effect of deeming certain beneficiaries homebound for purposes of meeting the Medicare home health benefit eligibility requirement that the patient be homebound. Under the law, the demonstration is to be conducted in 3 States (representing Northeast, Midwestern, western regions), with an overall participation limit of 15,000 persons. Section 702 requires the Secretary to collect data on effects of the demonstration on quality of care, patient outcomes, and any additional costs to Medicare. A report to the Congress addressing the results of the project is to specifically assess any adverse effects on the provision of home health services, and any increase (absolute and relative) in Medicare home health expenditures directly attributable to the demonstration. The Report is also to include recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purposes of absences from the home to qualify for home health services without incurring additional costs to the Medicare program. The purpose of the evaluation project is develop the information Congress seeks, to produce a technical evaluation report to accompany the Report to Congress, and to provide CMS with a sound basis for making the mandated recommendations. ■

Evaluation of MSA Plans Offered under the Medicare Program

Project No: HHSM-500-2006-00009I/06
Project Officer: Melissa Montgomery
Period: August 2007 to August 2009
Funding: $428,227.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The Case Study Report, September 2008, has been completed and can be found at: http://www.cms.hhs.gov/Reports/downloads/Tanamor.pdf The Focus Group report has been submitted to CMS and under review.

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

Evaluation of National DMEPOS Competitive Bidding Program

Project No: 500-00-0032/14
Project Officer: Ann Meadow
Period: September 2005 to September 2010
Funding: $2,331,309.00
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: In 2006, survey questionnaires and analysis plans were developed. In 2007, baseline beneficiary and supplier survey work in three sites, as well as site visits, were completed. Also in 2007, a report on early experience under the accreditation program was prepared. In 2008, the contractor delivered a preliminary report on results of the site visits they conducted. The contractor is adjusting the project plan in response to the program delay mandated by MIPPA.

Description: Section 302(b) of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) (MMA) required the Centers for Medicare and Medicaid Services (CMS) to begin in 2007 a program of competitive bidding for durable medical equipment (DME), supplies, certain orthotics, and enteral nutrients and related equipment and supplies in 10 Competitive Acquisition Areas (CAAs). Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 temporarily delayed and modified the competitive bidding program until 2009. This project's purpose is to provide information for the law's mandated Report to Congress on access to and quality of DME, beneficiary satisfaction with DME items and services, program expenditures, and impacts on beneficiary cost-sharing. Data collection activities include beneficiary surveys, focus groups with suppliers and referral agents, and key informant discussions with beneficiary groups or advocates, CMS officials or CMS' bidding contract managers, referral agents and suppliers.

Analysis of administrative data will supplement the primary data sources. ■

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

Project No: 500-00-0022/02
Project Officer: Mary Kapp
Period: September 2004 to September 2010
Funding: $2,662,583.00
Principal Investigator: Nancy McCall
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: An initial Report to Congress, issued in June 2007 (www.cms.hhs.gov/Reports/Downloads/McCall.pdf), provides an overview of the scope of the programs, program design and early implementation experience, and preliminary cost and quality findings. A second report (www.cms.hhs.gov/Reports/Downloads/McCall2008.pdf) provides interim findings on the first 18 months of the pilot programs. The evaluation is ongoing and will continue to assess the pilots through the end of operations. Final Phase I results will be presented to Congress in a third report.

Description: The purpose of this project is to independently evaluate chronic care improvement programs implemented under the developmental phase (Phase I) of the Voluntary Chronic Care Improvement Under Traditional Fee-for-Service Medicare initiative as authorized by Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). These pilot programs have been implemented under the name 'Medicare Health Support.' Eight organizations implemented care management programs in different geographic regions between 2005 and 2008. In each region, approximately 30,000 Medicare beneficiaries with heart failure or diabetes were identified as eligible; 20,000 were offered the intervention and the remaining 10,000 serve as a comparison population. ■

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

Project No: 500-00-0015/03
Project Officer: Beth Benedict
Period: September 2005 to June 2009
Funding: $999,938.00
Principal Investigator: Alan White
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

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

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

Evaluation of Programs of Coordinated Care and Disease Management

Project No: 500-95-0047/09
Project Officer: Carol Magee
Period: September 2000 to March 2008
Funding: $4,032,922.00
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The First and Second RTC have been released and are available. There is wide disparity in the enrollment success of the various sites, and locating and

convincing patients to enroll has been harder overall than anticipated. The Third Report to Congress has been released and is also available on CMS's web site.

Description: This 5-year evaluation project will describe and assess sixteen congressionally-mandated Medicare Coordinated Care Demonstration Programs, each providing a particular set of coordinated care interventions to fee-for-service (FFS) Medicare beneficiaries with one or more selected chronic illnesses (e.g., Diabetes, Chronic Obstructive Pulmonary Disease, Asthma, Hypertension, Hyperlipidemia, Stroke, Renal or Hepatic Disease, Coronary Artery Disease, Cancer). Demonstration of the effectiveness of programs of care coordination or management has historically been complicated by wide variations in program staff, funding mechanisms, interventions, and stated goals. The Balanced Budget Act of 1997 mandated demonstrations in separate program sites to implement approaches to coordinated care of chronic illnesses, along with an independent evaluation, for CMS to investigate the potential of care coordination and/or case management to improve care quality and control costs in the Medicare FFS Program. An evaluation of best practices in coordinated care and a study of demonstration design options were conducted. The 16 CMS-funded demonstration programs being studied as a part of this evaluation vary widely with respect to the demographics, medical, and social situations of the target population, intensity of services offered, interventions under study, type(s) of health care professionals delivering the interventions, and other factors. Each demonstration program has a randomized design, with a treatment arm and a 'usual care' arm. The evaluation can thus test each unique program's effects upon patient outcome(s)/well-being, patient satisfaction, provider behavior and satisfaction, and Medicare claims - attributable to particular methods of managing care in the FFS Medicare environment, and as compared to the respective "usual care," non-intervention patient group. The overall goals of this evaluation are to identify those characteristics of the programs of coordinated care under study that have the greatest impact on health care quality and cost and to identify the target populations most likely to benefit from such programs. In addition to analysis plans specific to each program/site, the evaluation contractor will conduct a process analysis to describe the interventions in detail, with a key goal of assessing what factors account for program success or failure. The study will include successive case studies of each of the 16 sites, interim and final site specific reports, two interim summary reports, two Reports to Congress (based on the interim summary reports), and a final summary report. Three sites were granted demonstration extensions, and CMS plans to continue to evaluate these sites. ■

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

Project No: 500-00-0033/02
Project Officer: Lorraine Johnson
Period: September 2002 to October 2008
Funding: $2,373,740.00
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

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

Description: Congress authorized the demonstration of programs of disease management to evaluate whether disease management in conjunction with a prescription drug benefit would improve care quality and health outcomes and reduce Medicare expenditures for fee-for-service Medicare beneficiaries with congestive heart failure, coronary artery disease or diabetes. Three disease management programs were selected to participate. The demonstration ended prematurely. None of the programs had impacts on the key outcomes of Medicare Part A and B expenditures and service use. Impacts on quality of care were small and limited to a few measures and observed only for one program. The pharmacy benefit did not have the anticipated impact on improving access to medications nor did its combination with disease management services have a positive impact on health care expenditures and quality of care. ■

Evaluation of Rural Community Hospital Demonstration

Project No: HHSM-500-2006-00006I/06
Project Officer: Linda Radey
Period: August 2007 to October 2011
Funding: $562,464.00
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The evaluator is preparing case studies of the original 9 hospitals enrolled in the demonstration.

Description: This project will evaluate the impact of the Rural Community Hospital Demonstration. The demonstration is examining effects of changes in Medicare reimbursements on the financial measures of small rural hospitals. Financial measures include financial viability and spending patterns. The contractor will also identify demonstration benefits to the community and whether the hospitals reached their goals. Nine rural hospitals are enrolled in the demonstration for five years; in the summer of 2008, four additional hospitals were added to the demonstration. CMS will reimburse demonstration hospitals at 100 percent of cost for inpatient care or a target amount, whichever is lower. The impact analysis will use Hospital Cost Reports Information System (HCRIS), the fiscal intermediary or MAC reconciliation of hospital cost report data during the demonstration period, to estimate the change in Medicare reimbursements due to the demonstration. The case study evaluation component will examine issues pertaining to the implementation and operational experiences of the participating hospitals using semi-annual reports filed by the demonstration hospitals and interviews with hospital officials. ■

Evaluation of Second Phase of Oncology Demonstration Program

Project No: HHSM-500-2006-00009I/02
Project Officer: Pauline Karikari-Martin
Period: August 2006 to February 2009
Funding: $654,447.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is in its second year of funding.

Description: This task order will evaluate how oncologists and hematologists adapted their practice in response to the CMS payment incentive, and to understand lessons learned for future demonstration projects involving oncologists and all specialists. The contractor will be required to design and conduct the evaluation of this demonstration. The evaluation will include collecting and analyzing primary and secondary data to examine issues that pertain to participation in this demonstration and system changes made within the physician office. Primary data will be collected from three sources: focus groups, site visits, and formal surveys. Secondary data will come from the CMS claims/billing system. This evaluation project offers a unqiue opportunity to capitalize on a nationwide demonstration, which involves data collection on how physician practices respond to financial incentives to collect and report data which is not normally collected on the claim form. ■

Evaluation of the Cancer Prevention and Treatment Demonstration

Project No: 500-00-0024/27
Project Officer: Karyn Anderson
Period: September 2005 to September 2010
Funding: $2,383,994.00
Principal Investigator: Janet Mitchell
Award: Task Order
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The enrollment period for the demonstration began October 2006 across three sites: Detroit, Hawaii and Utah/Montana. Enrollment began one month later for Newark and Baltimore sites. Enrollment at the Houston site began in April 2007. As of late 2008, 8,648 individuals have enrolled in the demonstration with a total of 7,982 in the screening arm and 666 in the treatment arm. In both the screening and treatment arms of the study, the numbers were roughly equivalent across the intervention and control groups. At the Detroit site, a total of 4,171 participants have been enrolled, with 3,862 in the screening arm and 309 in the treatment arm. At the Newark, NJ site, a total of 741 participants have been enrolled; 683 and 58 were enrolled in the screening and treatment arms respectively. Across the participating Indian reservations in Utah and Montana there are 1,172 total enrollees with 1,169 in the screening arm and three in the treatment arm.. In Baltimore, with 1,469 total participants, the vast majority (1,369) have been enrolled in the screening arm and 100 individuals have been enrolled into the treatment arm. The Houston site enrolled a total of 810 individuals, with 636 and 174 in the screening and treatment arms, respectively. At the Hawaii site, 285 total participants have been recruited, with 263 in the screening arm and 22 in the treatment arm. The evaluation is well underway. The first Report to Congress was completed in advance of the September

2008 deadline and has been signed by Secretary Leavitt. The final Report to Congress is due to Congress September 2010.

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

Evaluation of the Demonstration of Coverage of Chiropractic Services Under Medicare

Project No: 500-00-0031/07
Project Officer: Carol Magee
Period: September 2005 to September 2009
Funding: $1,553,273.00
Principal Investigator: William B. Stason
Award: Task Order
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Phase one of the contract ended in September 2007. Phase two has begun and another $372,132 was allocated to the funding. An interim, letter-format Report to Congress (RTC) draft has been prepared and is currently in circulation review at HHS. A final RTC, including a budget neutrality assessment, will be submitted to CMS in winter 2009.

Description: This Task Order is to assess the feasibility and advisability of expanding the coverage of chiropractic services under the Medicare program. The evaluation shall be conducted to: 1) Determine whether diagnostically 'eligible' beneficiaries who avail themselves of the expanded chiropractic services within the four demonstration treatment regions (i.e., 'users') utilize relatively lower or higher amounts of items and services for which payment is made under the Medicare program, than do comparison beneficiaries with approved NMS diagnoses treated medically within the respective control regions; 2) Determine the regional, overall, and service-specific costs for such expansion of chiropractic services under the Medicare program; 3) Ascertain the satisfaction, perceived functional status, and concerns of eligible beneficiaries receiving remibursable chiropractic services in the treatment regions; 4)Determine the quality fo the expanded chiropractic care received, based upon outcomes that can be derived from claims data; 5)Evaluate "... such other matters at the Secretary determines are appropriate...", which, within this contract, shall include determination of whether the demonstration achieved budget neutrality for the aggregate costs for beneficiaries with chiropractic-eligible NMS diagnoses, as well as the amount of any resultant savings or deficit to the Medicare program. Seven months into the Evaluation contract, Brandeis had completed site visits/interviews with the four demonstration regional CMS claims carriers, as well as with the respective American Chiropractic Association chapters. The OMB package for the proposed mailed satisfaction survey of 2,000 beneficiary recipients of expanded chiropractic services across the 4 demonstration regions was put into the 6-month review circulation for OMB approval in February 2006. OACT has just reviewed and approved, without revision, the contractor's proposal for the budget neutrality determination, as contained within the drafted Design Report. Currently underway is finalization of plans for impending selection of the 4 control regions and for the analysis of Medicare Claims data. ■

Evaluation of the Electronic Health Records Demonstration

Project No: HHSM-500-2005-00025I/06
Project Officer: Lorraine Johnson
Period: March 2008 to March 2016
Funding: $5,225,643.00
Principal Investigator: Jennifer Schore
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: Phase 1 of the demostration is expected to start June 1, 2009. The evaluation design report is in progress.

Description: This task order will evaluate the effectiveness of the Electronic Health Record (EHR) Demonstration authorized under Section 402 Medicare Waiver Authority. The goal of this five-year pay for performance demonstration is to promote high quality care through the adoption and use of health information technology/ electronic health records. The target population for the demonstration is primary care physicians in small to medium-size practices, in up to 12 sites, that provide primary care to Medicare FFS beneficiaries with diabetes, coronary artery disease, congestive heart failure, and other chronic diseases. ■

Evaluation of the Erickson Advantage CCRC Demonstration

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

Status: The contractor submitted a draft final report in September and is currently completing revisions to the report based on comments received. It is anticipated that the final report will be completed by the end of November 2008.

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

Evaluation of the Extended Medicare Coordinated Care Demonstration

Project No: HHSM-500-2005-00025I/12
Project Officer: Carol Magee
Period: September 2008 to September 2011
Funding: $497,522.00
Principal Investigator: Jennifer Schore
Award: Contract
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: This contract just commenced in September 2008. The draft of the Final (= 4th) Report to Congress on the MCCD demonstration is due to CMS in July 2009. It will cover quality of care, clinical, and cost outcomes, as well as process analyses, only for the two continuing MCCD programs: Health Quality Partners and Mercy Medical Center. [NB: Of the three programs that were granted a continuance by CMS, one program (QMed) chose not to continue.]

Description: The purpose of task order is to have one of CMS's existing Medicare Research and Demonstration (MRAD) Task Order contractors conduct the extended (second part) evaluation of the MCCD, which began in 2002, for those programs which were extended beyond the initial four year period of operations (i.e., 2002 - 2006) - for which findings were just reported in the Third Report to Congress (RTC). Eleven of the programs were extended up through a sixth year (2008). While eight of the 11 programs lacked evidence of cost-effectiveness after their initial four years of operation, and are ending in 2008, the other three programs have now been extended two more years, into spring of 2010. This task order will provide the cumulative evaluation of these eleven extended programs. There will be two major deliverables. The Final Fourth RTC (due to Congress in April 2010) will focus solely upon the three, more successful programs that were extended until 2010, and will necessarily be restricted to cumulative claims coverage from 2002 up through data available by December 31, 2008. In addition, it will provide an assessment of interventions and characteristics within

and/or across the three programs that appear to be associated with successful quality or cost outcomes. A subsequent Final Report to CMS (due in 2011) will encompass the total, cumulative claims analyses for each of these 11 extended MCCD programs, from 2002 until their respective closure dates, in either 2008 or 2010. The evaluation contract period of performance will run for 36 months, from September 2008 through September 2011. This evaluation of the cumulative experience for each of the 11 extended MCCD programs (running from 2002 through 2008 or 2010, respectively) will provide Congress and CMS with information important and relevant for future decisions regarding the cost-effectiveness and health outcomes of care coordination/disease management within the Medicare FFS milieu. Furthermore, within the three more-successful extended programs, identification of any associations of program characeristics or intervention process components with their quality of care and/or cost outcomes may delineate more specific models of care management success that can be tested in the future. ■

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

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

Status: The demonstration stopped following patients in winter 2007. The Final Report to Congress from this evaluation - summarizing findings over the entire 8-year demonstration, encompassing from one to six years of telemedicine follow-up for respective enrollees - has been prepared and is currently in circulation review at HHS.

Description: This contract for a second 4-year evaluation (Phase II, 2004 - 2008) of the IDEATel telemedicine diabetes demonstration (both of which were extended by the MMA 2003 into a Phase II, covering an additional 4 years) is essentially a follow-up of the evaluation done during Phase I of IDEATel, 2000-2004 (under the BBA 1997). Please refer to the Phase I evaluation contract (# 500-95-0055, TO 5) for background information. This Phase II evaluation will not only cover the 4 years of IDEATel's Phase II progress and outcomes between 2004 and 2008, but will also provide summary evaluation results across the entire 8 years of the demonstration's existence. ■

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

Project No: HHSM-500-2005-00025I/11
Project Officer: Lorraine Johnson
Period: August 2008 to February 2012
Funding: $120,699.00
Principal Investigator: Dominick Esposito
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The evaluation report for the first three years has been completed and will be available on the CMS Web site.

Description: The LifeMasters fee-for-service population based disease management demonstration was aughorized by Section 402(a)(1)(B) of Public Law 90-248, as amended (42 U.S.C. 1395b-1(a)(1)(b)). LifeMasters provides disease management services to chronically ill dual eligible fee-for-service Medicare beneficiaries in the state of Florida. The targeted conditions are congestive hear failure (CH), coronary artery disease (CAD0, and diabetesw. The goal of the program is to increase quality of care and reduce Medicare costs. The program is required to be budget neutral. It began January 1, 2005 and was scheduled to end December 31, 2007. CMS extended the LifeMasters program demonstration for an additional three years because it was beginning to show some positive results in Medicare cost savings and service utilization. The demonstration extension period is January 1, 2008 - December 31, 2010. For the extension, the evaluation contractor will be required to submit an interim summary report and a final report to CMS based on claims analysis. The reports will include examining the effects of the demonstration on quality of care processes, Medicare service utilization, and Medicare costs. ■

Evaluation of the Medical Adult Day-Care Services Demonstration

Project No: 500-00-0031/05
Project Officer: Susan Radke
Period: September 2005 to September 2009
Funding: $821,916.00
Principal Investigator: Walter Leutz
Award: Task Order (RADSTO)
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Brandeis University completed of phase one of the evaluation. Site visits to all five demonstration sites were conducted. The contractors met with administrators, staff, demonstration participants, and those who declined to participate in the demonstration. Brandeis drafted a satisfaction survey for phase two of the study utilizing information from beneficiary face to face interviews. The satisfaction survey was approved by OMB under the Paperwork Reduction Act. The contractor is currently fielding the beneficiary survey and has begun phase two activities which includes the bulk of the quantitative analysis.

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

Evaluation of the Medicare Care Management for High Cost Beneficiaries Demonstration

Project No: 500-00-0024/25
Project Officer: David Bott
Period: September 2005 to March 2009
Funding: $1,784,544.00
Principal Investigator: Nancy McCall
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Initial site visits are complete and reports based on those visits plus an analysis of each program's outreach activities were included in the evaluation contractor's 2nd annual report. The beneficiary survey covering all six programs is complete and the report is pending release in the evaluation contractor's 3rd annual report. Claims data collection will continue up to 9 months after the operating period.

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

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

Project No: 500-00-0033/05
Project Officer: Lorraine Johnson
Period: September 2004 to September 2009
Funding: $1,707,028.00
Principal Investigator: Lorenzo Moreno
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The period of performance was extended through December 2009.

Description: The purpose of this project is to evaluate the effectiveness of the Medicare Care Management Performance (MCMP) Demonstration as mandated by section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The evaluation includes a comprehensive case study component to examine issues pertaining to the implementation and operational experiences of the participating practices. The evaluation contractor will conduct various statistical analyses of secondary data, including individual beneficiary-level data, to examine issues related to quality-of-care and impacts on the use and costs of services. Primary data are being collected through interviews of key personnel at participating practices and interviews with beneficiaries and physicians. ■

Evaluation of the Medicare Medical Home Demonstration

Project No: HHSM-500-2005-00029I/16
Project Officer: Mary Kapp
Period: September 2008 to September 2013
Funding: $2,971,101.00
Principal Investigator: Nancy McCall
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Design of the evaluation is under way. The demonstration is scheduled to begin January 1, 2010.

Description: The purpose of this project is to design and conduct an evaluation of the Medicare Medical Home Demonstration. The 3 year demonstration is authorized by Section 204 of the Tax Relief and Health Care Act of 2006 and will "provide targeted, accessible, continuous and coordinated family-centered care to high needs populations." Under this demonstration, personal physicians will receive a monthly management fee payment for each Medicare beneficiary enrolled in the medical home. The demonstration will be conducted in a mix of large and small practices in up to 8 states. CMS will begin recruiting practices in early 2009, for a scheduled start date of January 1, 2010. The evaluation will identify key features of practices providing medical home services to Medicare beneficiaries. The finding s from the analyses will be used to prepare the annual Reports to Congress as directed by the legislation. ■

Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration

Project No: 500-00-0024/05
Project Officer: Penny Mohr
Period: September 2002 to March 2008
Funding: $2,545,139.00
Principal Investigator: Gregory Pope
Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The final report on the PPO demonstration plan offerings and enrollment has been completed. This report addresses three key outcomes of the PPO demonstration: availability of PPOs, plan offerings, and enrollment. In addition, a final report on the beneficiary survey results was submitted and approved. The survey analysis focused on three main questions central to understanding the demonstration: • Do beneficiary characteristics vary by plan type? • What factors affect beneficiary plan choice? • How do beneficiary experience and rating of health care vary by plan type? This report is available from the Project Officer upon request. The project is complete.

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

Evaluation of the Nursing Home Value Based Purchasing Demonstration

Project No: HHSM-500-2006-00009I/07
Project Officer: William Buczko
Period: September 2008 to September 2012
Funding: $699,807.00
Principal Investigator: Lisa Green
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project kickoff meeting was held on September 22, 2008. The project evaluation plan will be submitted to CMS in late 2008.

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

Evaluation of the Part D Payment Demonstration

Project No: 500-00-0024/23
Project Officer: Aman Bhandari
Period: September 2005 to June 2009
Funding: $995,434.00
Principal Investigator: Leslie Greenwald
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The evaluation design was submitted and approved. In addition several reports have been completed including the "Medicare Part D Payment Demonstration Site Visit Report" and the "Medicare Part D Payment Demonstration Focus Group Report", both of which have been posted on the CMS Web site. Two additional reports have been completed as of November 2008: 1. Part D Payment Demonstration Evaluation Plan Benefit Design Analysis 2. Part D Payment Demonstration Enrollment Analysis

Description: This project focuses on evaluating the impact of the Medicare Part D payment "reinsurance" demonstration. CMS has announced its intent to conduct a demonstration that represents an alternative payment approach for private plans offering prescription drug coverage under Part D. The demonstration is expected to increase the number of offerings of supplemental prescription drug benefits through enhanced alternative coverage. The purpose of this demonstration was to "allow private sector plans maximum flexibility to design alternative prescription drug coverage." This evaluation examines the impact of the demonstration on beneficiaries, drug plan sponsors (PDPs and MA-PDs), and Medicare program costs. From the beneficiary perspective, the evaluation focuses on the availability of, and enrollment in, enhanced alternative benefit packages offered by drug plan sponsors, as well as enrollees' patterns of utilization. The evaluation also explores the advantages and disadvantages of participation from the perspective of drug plan sponsors and the Medicare program (Federal Register, Vol. 70, No. 37). Both primary (site visits, focus groups) and secondary CMS data sources are being used in the evaluation of this demonstration. ■

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

Project No: 500-00-0033/01
Project Officer: Fred Thomas
Period: September 2001 to March 2009
Funding: $2,452,864.00
Principal Investigator: Valerie Cheh
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: Evaluation work on permanent PACE is near completion and the Report to Congress is under review by the Department of Health and Human Services. The Report on for-profit PACE is not feasible at this time due to a lack of providers and data. A supplemental report on a community-based practice model named "How Integrated Care Programs Use Community-Based, Primary Care Physicians" was completed and is available on the Web site at http://www.cms.hhs.gov/reports/downloads/cheh.pdf.

Description: This project is an evaluation of the Program for All-inclusive Care for the Elderly (PACE) as a permanent Medicare program and as a State option under Medicaid. The project evaluates PACE in terms of site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data and other comparable populations. This project expands on the foundations laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment and assessing the impact of higher end-of-life costs and long-term nursing home care. ■

Evaluation of the Rural Hospice Demonstration

Project No: 500-00-0026/04
Project Officer: Linda Radey
Period: September 2005 to September 2010
Funding: $400,232.00
Principal Investigator: Jean Kutner
Andrew Kramer
Cari Levy
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

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

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

Evaluation of the Senior Risk Reduction Program

Project No: HHSM-500-2006-00007I/07
Project Officer: Pauline Karikari-Martin
Period: September 2008 to September 2013
Funding: $1,009,720.00
Principal Investigator: Sharon Benus
Award: Task Order (XRAD)
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: Awarded to XRAD contractor IMPAQ in September of 2008.

Description: The purpose of this Task Order is to evaluate the effectiveness of the Senior Risk Reduction Demonstration (SRRD) in health promotion, health management, and disease prevention. The objectives of the SSRD interventions are to improve the health

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

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

Project No: 500-00-0032/06
Project Officer: Ann Meadow
Period: September 2002 to November 2007
Funding: $419,501.00
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: A case study report on the first year of project implementation has been accepted. The demonstration has ended. The contractor prepared reports on other DME coverage issues pertaining to mandated consumer service standards mandated in the Medicare Modernization Act of 2003. Draft standards were presented to the Program Advisory Oversight Comittee, during an open door forum, and posted on the CMS Web site for a 60-day public comment period. More than 5,000 commenters responded to the draft standards. The draft standards are being revised based on public comments and will be published through CMS program instructions. In the project's late stages, the early accreditation program which CMS set up was examined. The evaluation's standards were used as a basis for creditation. The project is now complete.

Description: The purpose of this task order is to conduct a preliminary case-study evaluation of a four-site initiative. The descriptive evaluation will compare and contrast the purchasing of wheelchair equipment in these sites with those utilized in fee-for-service and in managed care models which serve people with disabilities. The study will propose further evaluation design options for CMS consideration and related feasibility studies of other DME. This initiative tests, at a local level, an important collaboration between the Department of Health and Human Services and the Department of Education intended to improve beneficiary access and satisfaction with the purchase and maintenance of wheelchair equipment. Section 1834(a) of the Social Security Act as amended by Section 302 of the Medicare Modernization Act of 2003 requires the Secretary to establish quality standards for DMEPOS suppliers to be applied by accreditation organizations. In June 2005, this contract was modified based on findings from the evaluation and to meet the needs of this statute. This modified scope of work, i.e., quality standards for specific durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), consistent with the original scope of work, will provide information of use to beneficiaries and advocacy groups, CMS, the Department of Education, States, health plan contractors, and community DMEPOS suppliers. This additional task, developing service and quality assurance standards for specific DMEPOS items is also fundamental to consumer access to equipment that will be safely and appropriately used. These standards will assist the beneficiary to know what to expect from suppliers and what constitutes high quality service. Beneficiary education, a key feature of the scope of work in the current contract, is a fundamental aspect of the new task proposed in this modification. The assumption is that beneficiaries who are educated about the safe and proper use of their equipment will experience better outcomes with the equipment. This additional task continues the beneficiary involvement in the process of obtaining and appropriately using DMEPOS. ■

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

Project No: HHSM-500-2006-00005I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $ 1,000.00
Principal Investigator: C. William Wrightson
Award: Task Order Contract, Base
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: This contract is an umbrella contract and is in its second year. Currently there are seven (7) task orders issued under this contract.

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

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

Project No: HHSM-500-2006-00006I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $ 1,000.00
Principal Investigator: Thomas MaCurdy
Award: Task Order Contract, Base
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: This contract is an umbrella contract and is in its second year. Currently, there are sixteen (16) task orders awarded under this contract.

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

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

Project No: HHSM-500-2006-00007I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $ 1,000.00
Principal Investigator: Sharon Benus
Award: Task Order Contract, Base
Awardee: Impaq International LLC
10420 Little Patuxent Parkway
Columbia, MD 21044

Status: This is an umbrella contract and is in its second year. Currently there are ten (10) task orders issued under this contract.

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

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

Project No: HHSM-500-2006-00008I
Project Officer: Leslie Mangels
Period: March 2006 to March 2011
Funding: $ 1,000.00
Principal Investigator: David Kennell
Award: Task Order Contract, Base
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: This is an umbrella contract and is in its second year. Currently there are three (3) task orders issued under this contract.

Description: This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this contract CMS may award task orders for projects that involve a range of R&D activities. These

projects will relate to the Medicare, Medicaid, the State Children's Health Insurance Program (MM/SCHIP) issues. Individual projects will be initiated through award of specific task orders. ■

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

Project No: HHSM-500-2006-00009I
Project Officer: Leslie Mangels
Period: April 2006 to April 2011
Funding: $ 1,000.00
Principal Investigator: Lisa Green
Award: Task Order Contract, Base
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: This is an umbrella contract and is in its second year. Currently there are nine (9) task orders awarded under this contract.

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

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

Project No: HHSM-500-2006-00010I
Project Officer: Leslie Mangels
Period: April 2006 to April 2011
Funding: $ 1,000.00
Principal Investigator: Ellen McNeil
Award: Task Order Contract, Base
Awardee: Pacific Consulting
PO Box 42026
Palo Alto, CA 94306

Status: This is an umbrella contract and is in its second year. Currently there is one (1) task order awarded under this contract.

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

Exploratory Research on Medication Therapy Management

Project No: HHSM-500-2005-00018I/03
Project Officer: Steve Blackwell
Period: September 2006 to July 2008
Funding: $450,000.00
Principal Investigator: Andrea Hassol
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The study ended July 14, 2008. The study found common features among MTMPs. For example, most rely on pharmacists as the primary service provider. They start with a comprehensive medication review and include reconciliation of drug therapy with prescribers. Most also include some patient education and monitoring. However, within this broad framework, there are a wide variety of practice models. The evidence to date does not allow us to determine which practice model or elements are important contributors to clinical outcomes. Although in their infancy, some Medicare MTMPs are conducting careful research with strong methodological designs to learn from early experiences, which could be of benefit to CMS in refining the MTM program. The study also found some areas where the program could continue to be refined. For example, while the separation of MTMPs from disease management (DM) programs is uncommon in non-Medicare sectors, opportunities for coordination with stand alone PDPs may be few, potentially resulting in duplication of services. Also, Part D plans are required to offer MTM services to eligible institutionalized patients, but there is an overlap with the responsibilities of consultant pharmacists in nursing homes.

Description: This task order is being conducted to help inform CMS decision making about MTM and specifically to help CMS identify and understand

attributes of MTM programs that may be most effective for the Medicare Program including: the organization types providing MTM; the services and interventions included; the providers involved; how beneficiaries are targeted; the differences from and integration with disease management (DM) programs; the financial structures; and resultant outcomes. To answer these questions an information scan and case studies of Medication Therapy Management Programs (MTMPs) in the public and private sectors will be conducted. ■

Family or Individual Directed Community Services (FIDCS) Research

Project No: HHSM-500-2006-00006I/09
Project Officer: Mary Sowers
Period: September 2007 to September 2011
Funding: $553,060.00
Principal Investigator: Ursula Bischoff
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contract was modified so that the funding was increased and the period of performance was extended.

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

Federal-State Health Reform Partnership

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

Status: As of October 30, 2008, 289,175 individuals were participating in the demonstration.

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

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

Project No: 11-W-00117/04
Project Officer: Melissa Harris
Period: October 1998 to March 2008
Funding: $ 0.00
Principal Investigator: Danielle Reatherford
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive, Mail Stop 8
Tallahasee, FL 32308

Status: CMS approved a one-month extension of 1115 authority, through March 31, 2008. On this date, the program transitioned to a 1915(j) Self-Directed Personal Assistance Services State Plan program, utilizing a new

authority given through the Deficit Reduction Act of 2005.

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

Florida Family Planning Waiver

Project No: 11-W-00135/4
Project Officer: Lane Terwilliger
Period: August 1998 to November 2009
Funding: $ 0.00
Principal Investigator: Carlton Snipes
Award: Waiver-Only Project
Awardee: Agency for Healthcare Administration
2727 Mahan Drive, Mail Stop 8
Tallahasse , TN 32308

Status: As of 8/7/2008, 15,075 individuals received family planning services through the demonstration.

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

Florida Medicaid Reform

Project No: 11-W-00206/04
Project Officer: Mark Pahl
Period: October 2005 to June 2011
Funding: $ 0.00
Principal Investigator: Carlton Snipes
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive, Mail Stop 8
Tallahasee, FL 32308

Status: The Florida Medicaid Reform demonstration was approved October 19, 2005 and implemented July 1, 2006. The State initially implemented Reform in Broward and Duval Counties, then expanded to Baker, Clay and Nassau Counties July 1, 2007. Further expansion is pending approval by the Florida legislature. The State has submitted a request to amend the demonstration to allow expenditures relating to certain 1915(b)(3) services. As of December 2008 this request remains under CMS review.

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

Geographic Variation in Prescription Drug Spending

Project No: HHSM-500-2006-00006I/02
Project Officer: Jesse Levy
Period: August 2006 to April 2009
Funding: $185,971.00
Principal Investigator: Grecia Marrufo
Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The Report to Congress is in clearance. The contractor has delivered the draft final report.

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

Global Commitment to Health

Project No: 11-W-00194/01
Project Officer: Jacqueline Roche
Period: September 2005 to September 2010
Funding: $ 0.00
Principal Investigator: Susan Besio
Award: Waiver-Only Project
Awardee: Vermont Department of Social Welfare, Office of Health Access, Agency of Human Services
312 Hurricane Lane, Suite 201
Williston,VT 05495

Status: As of 9/30/2008, 162,197 individuals were enrolled in the Global Commitment to Health Demonstration, including 27,911 enrolled in the pharmacy benefit program and approximately 7,000 receiving premium assistance or enrolled in the Catamount Health Program.

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

Hawaii QUEST Expanded

Project No: 11-W-00001/09
Project Officer: Diane Gerrits
Edward Hutton
Period: July 1993 to June 2013
Funding: $ 0.00
Principal Investigator: Kenneth Fink
Award: Waiver-Only Project
Awardee: Hawaii Department of Human Services, Med-Quest Division
P. O. Box 700190
Kapolei, HI 96709-0190

Status: The Demonstration remains operational. The State is in the process of implementing the QExA program.

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

adjustments to disproportionate share hospitals. SCHIP-eligible children also receive their coverage through the delivery system created by QUEST Expanded. In February 2008, CMS extended the demonstration for 5 years under section 1115(a) because the State substantially expanded the demonstration by the addition of the Quest Expanded Access (QExA) program. In QExA, four of the State's home and community based services (HCBS) waivers and all long term care services for the aged, blind and disabled (ABD) populations were added to the demonstration. Currently only the funding stream for the HCBS programs has changed as they are operating as "look alike" programs. ABD beneficiaries will be migrated to a capitated managed care delivery system for all covered services, including HCBS and facility based long-term care when QExA is operational. The implementation date was originally November 1, 2008, but was moved to February 1, 2009. ■

Hawaii Rural Health Interdisciplinary Training Demonstration Project

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

Status: This grant was extended with no additional costs to December 31, 2009.

Description: The focus of this project is to develop interdisciplinary, collaborative and culturally appropriate family medicine residency, nursing and allied health professions training in rural Hawaii, with a goal of reducing health disparities and improving access to culturally appropriate care for native Hawaiians and underserved populations. Hawaii is a state that is geographically isolated and has an uneven distribution of physicians and health care providers. Most are clustered around tertiary care hospitals in Honolulu. Medical education and health professions training sites likewise are largely limited to O'ahu with the exception of associate-level nursing programs in the community college system. Thirty percent of the population are scattered on the remaining isolated and rural neighbor islands. Native Hawaiians represent 20% of the population, and carry a disproportionate burden of disease. For example, Native Hawaiians have rates of type II diabetes that are four times higher than the US standard population, and mortality rates from diabetes eight times that of non-Hawaiians. Failure to address these disparities will lead to significant health care costs for the state and federal governments in the future. This project relies on a development of a partnership between the Hilo Medical Center and community and the University of Hawaii Department of Family Medicine and Community Health. They plan to develop an ACGME-accredited three year Rural Family Medicine training program that emphasizes Native Hawaiian health. This program will catalyze a broader interdisciplinary training collaborative to develop culturally-appropriate and accessible care, as well as community-appropriate strategies for training nursing, social work, nutrition and other allied health professionals. The focus will be on improving hospital-community collaboration and team care for Native Hawaiians and underserved persons with chronic illness in order to reduce health disparities. ■

Healthier Mississippi

Project No: 11-W-00185/04
Project Officer: Mark Pahl
Period: September 2004 to September 2009
Funding: $ 0.00
Principal Investigator: Robert L. Robinson
Award: Waiver-Only Project
Awardee: Mississippi, Office of Governor, Division of Medicaid
Robert E. Lee Building, 239 N. Lamar St., Suite 801,Hinds County
Jackson, MS 39201

Status: On September 29, 2008 the State requested a 3 year exension of the demonstration. CMS must render a decision on the extension no later than March 29, 2009.

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

likely become eligible for Medicaid at a greater cost to the State. ■

Healthy Indiana Plan

Project No: 11-W-00237/05
Project Officer: Juliana Sharp
Period: December 2007 to December 2011
Funding: $ 0.00
Principal Investigator: Jeffery Wells
Award: Waiver-Only Project
Awardee: Indiana, Family and Social Services Administration
403 W. Washington Street, Room W382
Indianapolis, IN 46204-2740

Status: The Demonstration was approved on December 14, 2007, and was implemented January 1, 2008. On September 23, 2008, the State submitted a section 1115 demonstration amendment to implement 2 cost saving projects as required by the Special terms and conditions.

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

Home Health Datalink File--Phase III

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

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

Description: The Balanced Budget Act of 1997 mandated dramatic changes in several areas of Medicare services, including the home health benefit. The Act mandated a home health prospective payment system (PPS), to be preceded by an interim payment system (IPS) until the PPS could be implemented. In place from late 1997 to October 2000, the IPS led to sharp reductions in numbers of home health agencies and home health utilization by Medicare beneficiaries. Policymakers will want information on the full impact of this succession of changes. Therefore, data development for such studies is needed by the Department and will be in demand by external researchers and policymakers. Under this project, the contractor annually provides a comprehensive, data-analytic file covering the entire PPS period to date. The file serves the medium-term needs

of policymakers regarding the Medicare home health benefit. In addition, the file will meet the internal needs of CMS and the Department in the areas of payment refinements, quality improvement, and program integrity. The contractor is also tasked with providing certain technical assistance and analytical programming support using the products of the contract. ■

Home Health Demonstrations: Technical Support

Project No: 500-00-0032/09
Project Officer: Bertha Williams
Period: July 2004 to February 2009
Funding: $1,331,399.00
Principal Investigator: Henry Goldberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

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

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

Home Health Pay for Performance Demonstration

Project No: HHSM-500-2005-00018I/04
Project Officer: James Coan
Period: September 2006 to March 2009
Funding: $542,231.00
Principal Investigator: Henry Goldberg
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

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

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

Home Health Third Party Liability Demonstration Arbitration

Project No: HHSM-500-2005-00033I
Project Officer: Juliana Tiongson
Period: September 2005 to September 2010
Funding: $763,000.00
Principal Investigator: S. Paret
Award: Contract
Awardee: American Arbitration Association
601 Pennsylvania Avenue, NW
Washington, DC 20004-2676

Status: CMS has obtained legal representation during the arbitration hearings. Hearings covering Fiscal Year 2001 cases concluded in November 2008. The next round of arbitrations is scheduled to begin in January 2009.

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

Illinois Family Planning

Project No: 11-W-00165/5
Project Officer: Lane Terwilliger
Period: June 2003 to March 2009
Funding: $ 0.00
Principal Investigator: Theresa Eagleson-Wyatt
Award: Waiver-Only Project
Awardee: Illinois Department of Public Aid, Medicaid and SCHIP Programs
201 S, Grand Avenue, East 3rd Floor
Springfield , IL 62763-0001

Status: On 10/15/2008, Illinois submitted a request for a three-year extension for the demonstration. As of 9/1/2008, 63,590 individuals received family planning services through the demonstration.

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

Impact of Increased Financial Assistance to Medicare Advantage Plans

Project No: 500-00-0024/17
Project Officer: Melissa Montgomery
Period: August 2004 to April 2009
Funding: $1,199,931.00
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The Report to Congress can be found here: http://www.cms.hhs.gov/reports/downloads/Pope.pdf The MA Monitoring Report can be found here: http://www.cms.hhs.gov/Reports/downloads/Pope-2007.pdf The final report has been approved and placed on the web.

Description: Section 211(g) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Secretary of Health and Human Services report to Congress, no later than July 1, 2006, on the impact of additional funding provided under MMA and other Acts including the Balanced Budget Refinement Act of 1999 and the Beneficiary Improvement and Protection Act of 2000 on the availability of Medicare advantage (MA) plans in different areas and the impact on lowering premiums and increasing benefits under such plans. The purpose of this project is to develop and implement a monitoring system with key indicators of health plan performance. Key indicators both nationwide and within market areas will be used to support the report to Congress required by section 211(g) of the MMA. Originally, this contract was to be completed in late 2005; however, in 2006 extensive program-wide changes (e.g., regional plans, competitive programs, and Part D drug benefit) were implemented concurrently. As a result, it became necessary to exercise the contract option in order for the contractor to continue to monitor the MA program. The period of performance was extended to 2009. Forthcoming are reports for 2006, 2007, and 2008. ■

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

Project No: 500-00-0033/09
Project Officer: Iris Wei
Period: June 2005 to June 2009
Funding: $1,333,834.00
Principal Investigator: Valerie Cheh
Arnold Chen
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor has submitted two annual reports to CMS. However, the second report took the form of a memorandum in describing the contractor's responses and plan of actions to CMS' comments.

Description: This study will assess the impact of the changes in payments for Part B covered drugs on beneficiaries, providers and the distribution and delivery system for the drugs. The study will cover a broad array of drugs and physician specialties and analyze the effects of the payment reforms from 2004-2007. While the focus will be on the payment reform for drugs currently covered under Part B, the study will need to consider other provisions of the MMA that might affect the utilization of these drugs. ■

Impacts Associated with the Medicare Psychiatric PPS

Project No: 500-00-0024/18
Project Officer: Fred Thomas
Period: September 2004 to September 2009
Funding: $839,772.00
Principal Investigator: Jerry Cromwell
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: A report on psychiatric co-morbidities has been released and is on the CMS Web site. The project received a no-cost extension and will now run until September 2009.

Description: To understand how the flow of patients between the inpatient and outpatient modalities has changed as a result of changes to a prospective payment system, as well as to understand changes in the delivery of mental health care in the last decade, this project seeks information in the following specific areas: • The role played by smaller psychiatric inpatient units and facilities. • The use of partial hospitalization and outpatient programs in complementing and substituting for inpatient care. • The use of two prospective payment systems to pay for essentially the same inpatient services. ■

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

Project No: 500-00-0024/13
Project Officer: Jody Blatt
Period: September 2003 to September 2009
Funding: $4,494,082.00
Principal Investigator: Michael Trisolini
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: In FY 2008 the work related to the PGP demonstration was shifted to a new contract. Work for the MCMP demonstration will continue under this contract through September 29, 2009. In the spring of 2008, practices were paid an incentive for reporting baseline data in January, 2008. In addition, in the summer of 2008, practices participating in this demonstration were able to earn PQRI incentive payments through their participation in the demonstration without having to submit duplicative data. The first pay for performance year will be based on data from the first full demonstration year (July 2007-June 2008). That data will be collected in early 2009.

Description: This contract was originally awarded in 2003 to support the implementation and evaluation of the Physician Group Practice (PGP) Demonstration,

Medicare's first pay-for-performance initiative for physicians in large multi-specialty group practices. In 2005, the contract was modified to incorporate clinical quality measure data collection and related tasks for the Medicare Care Management Performance (MCMP) Demonstration, a pay for performance demonstration for smaller primary care group practices in four states (Arkansas, Utah, California, and Massachusetts). The MCMP demonstration was authorized under section 649 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. The goal of this demonstration is to improve the quality of care for chronically ill Medicare beneficiaries while encouraging the implementation and adoption of health information technology by primary care physicians. Under this demonstration, physician groups will receive financial incentives based on performance on 26 clincical quality measures related to the care of beneficiaries with diabetes, congestive heart failure, coronary artery disease, and preventive care services. In addition, they will be eligible to earn additional bonuses if the quality measure data is submitted electronically from a CCHIT-certified electronic health record. The demonstration began July 1, 2007 with almost 700 practices and will run through June 30, 2010. ■

Implementation and Monitoring, Support of the Medicare Hospital Gainsharing Demonstration

Project No: HHSM-500-2006-00005I/03
Project Officer: Lisa Waters
Period: August 2006 to August 2010
Funding: $1,792,012.00
Principal Investigator: David McKusick
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The project is now fully funded.

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

Implementation of ESRD Bundled Payment and Pay-for-Performance

Project No: HHSM-500-2006-00005I/02
Project Officer: Henry Bachofer
Period: August 2006 to September 2011
Funding: $498,862.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

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

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

Implementation of the Physician Group Practice Demonstration

Project No: HHSM-500-2005-00029I/07
Project Officer: John Pilotte
Fred Thomas
Period: September 2007 to September 2010
Funding: $2,229,948.00
Principal Investigator: Gregory Pope
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Currently, the demonstration is in its fourth performance year.

Description: Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Physician Group Practice Demonstration rewards physicians for improving the quality and cost efficiency of health care services delivered to a Medicare fee-for-service population. Under the demonstration, physician groups continue to be paid under regular Medicare fee schedules and may share in savings derived care management programs and quality improvement initiatives. Physician groups may earn performance payments of up to 80% of the savings they generate. The Medicare Trust Funds retain at least 20% of the savings. Performance payments are divided between cost efficiency for generating savings and performance on 32 ambulatory care quality measures, focusing on common chronic conditions and preventive care, phased in during the demonstration. At the end of the second performance year, all 10 of the participating physician groups continued to improve the quality of care for chronically ill patients by achieving benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, coronary artery disease and congestive heart failure. The physician groups increased their quality scores an average of 9 percentage points across the diabetes mellitus measures, 11 percentage points across the heart failure measures, and 5 percentage points across the coronary artery disease measures. As a result, all physician groups received at least 96 percent of their PQRI incentive payments which they agreed to place at risk for quality performance under the demonstration. The 10 physician groups earned PQRI incentive payments totaling $2.9 million. In addition, four physician groups earned $13.8 million in performance payments for improving the quality and cost efficiency of care as their share of a total of $17.4 million in Medicare savings. Additional physician groups had lower growth in expenditures than their local market area, but not sufficiently lower to share in savings under the demonstration's performance payment methodology. In total, the 10 physician groups earned performance payments for improving the quality and efficiency of care totaling $16.7 million in the second performance year. ■

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

Project No: HHSM-500-2005-00029I/01
Project Officer: Henry Bachofer
Period: September 2005 to September 2011
Funding: $1,851,987.00
Principal Investigator: Gregory Pope
Award: Task Order
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Site specific demonstration designs are under development. A modification has been made to the contract where total funds currently available for payment and allotted to this task order are increased by $500,000.00. It is estimated that the amount currently allotted will cover payment for the contractor's performance of work through March 31, 2010.

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

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

Project No: 500-00-0033/12
Project Officer: Juliana Tiongson
Period: September 2005 to September 2010
Funding: $698,719.00
Principal Investigator: Randall S. Brown, Ph.D.
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor continues to provide technical assistance in developing, refining and implementing demonstrations. The contractor has performed waiver cost estimates for the FESC demonstration and the Medicare Hospital Gainsharing Demonstration.

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

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

Project No: 500-00-0028/03
Project Officer: Siddhartha Mazumdar
Henry Bachofer
Period: September 2004 to September 2009
Funding: $2,180,974.00
Principal Investigator: Frederich Port, M.D.
Award: Task Order (RADSTO)
Awardee: Arbor Research Collaborative for Health formerly known as URREA (University Renal Research and Education Association)
315 West Huron, Suite 260
Ann Arbor, MI 48103

Status: Arbor Research (formerly URREA) has developed clinical measures for determining the Quality Incentive Payment and has implemented data transfers for the 3 participating demonstration organizations. The contractor has also performed calculations of whether the organizations have met targets established for each of the clinical measures. The organizations began enrolling ESRD patients early in 2006. Arbor Research has conducted the first three semi-annual reconciliations, determining the quality incentive payment for the organizations.

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

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

Project No: HHSM-500-2006-00005I/04
Project Officer: Lisa Waters
Period: August 2007 to August 2011
Funding: $689,088.00
Principal Investigator: Sally Burner
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The demonstration is slated to begin early 2009.

Description: This demonstration project will provide a test of gainsharing in the Medicare program. It will determine if gainsharing can align incentives between hospitals nad physicians in order to improve the quality and efficiency of care. The goal is to improve hospital quality, while focusing on operational and financial performance. The Contractor will provide overall implementationa nd monitoring support for the 3-year demonstration. CMS plans to award a separate contract to an organizatin for the purpose of evaluating the Physician Hospital Collaboration Demonstration. ■

Implementing the HEDIS Medicare Health Outcomes Survey

Project No: HHSM-500-2004-00015I/01
Project Officer: Sonya Bowen
William Long
Chris Haffer
Period: September 2004 to September 2009
Funding: $3,750,993.00
Principal Investigator: Kristen Spector
Award: Task Order
Awardee: National Committee for Quality Assurance
1100 13th Street, NW
Washington, DC 20005

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

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

Improving End of Life Care Through Technology

Project No: 1C0CMS030280/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $383,181.00
Principal Investigator: Karen Nichols
Award: Grant
Awardee: Valley Hospice, Inc.
10686 State Route 150
Rayland, OH 43943

Status: This project is underway; the notification letter was sent June 27, 2008.

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

Improving HIV/AIDS Care and Treatment for Vulnerable Populations

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

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The objective of this project is to provide comprehensive HIV outreach, testing, and referral services for at least 325 high-risk, low-income men and women who are currently not receiving medical care. ■

Improving Nursing Home Compare

Project No: HHSM-500-2005-00018I/05
Project Officer: Leslie Boyd
Period: June 2008 to December 2009
Funding: $554,854.00
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project is underway.

Description: The Centers for Medicare and Medicaid Services (CMS) engages in a number of activities to improve the quality of care in nursing homes. Among these are activities such as consumer awareness and value-based purchasing. To promote consumer awareness, CMS seeks to provide an array of understandable information that can be readily accessed by the public. Thus CMS maintains a web site that features "Nursing Home Compare ", a resource that gives consumers comparative information on nursing home performance. Among other things, this resource includes certain quality measures (QMs) that are derived from information collected via the minimum data set (MDS). Under the existing contract, CMS is planning to implement the Nursing Home Value-Based Purchasing (NHVBP) demonstration to improve the quality of care furnished to Medicare beneficiaries residing in nursing homes. CMS will assess the performance of participating nursing homes on selected quality measures, and then will make payments to nursing homes that have the best performance or the greatest improvement in quality of care. The domains of quality selected for the demonstration are: nurse staffing, avoidable hospitalizations, quality measures based on MDS, and information from State survey and certifications. CMS plans to improve Nursing Home Compare through the inclusion of a national nursing home rating system. We currently envision using a "five-star" rating system. The goal of the rating system is to provide useful information to consumers about how each nursing home performs in terms of quality. The rating system must be easy to understand while making meaningful distinctions in quality among nursing homes. CMS intends to implement the new system by the end of 2008. Future improvements to the system will also be considered. ■

Improving Nursing Home Enforcement - Phase 2

Project No: 500-00-0026/03
Project Officer: Jean Scott
Period: September 2003 to September 2008
Funding: $2,393,163.00
Principal Investigator: Andrew Kramer
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: This project concluded at the end of September 2008. The State Promising Practices briefs have been placed on CMS's website, the case studies report, the nurse aide training report, and the development of the analytic method to identify facilities for additional survey attention have been completed.

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

Improving Outcomes Using Medicare Health Outcomes Survey Data

Project No: GS-10F-0166/HHSM-500-2006-00001G
Project Officer: William Long
Period: November 2005 to March 2009
Funding: $3,386,972.00
Principal Investigator: Laura Giordano
Award: GSA Order
Awardee: Health Services Advisory Group
1600 East Northern Avenue, Suite 100
Phoenix, AZ 85020

Status: Round eleven data submission, cleaning, and analysis from the 2008 HOS field administration will be completed in early 2009. Cohort nine performance measurement and cohort eleven baseline results will be finalized and made available later in 2009. Fiscal Year 2009 activities will also include comparative analyses between the Medicare managed care and fee-for-service populations on differential health status, health care utilization and expenditures, and care satisfaction.

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

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

Project No: 500-00-0032/07
Project Officer: Jean Scott
Period: September 2003 to June 2008
Funding: $1,737,772.00
Principal Investigator: Alan White
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The 5-State demonstration began in September 2005 and consisted of surveys of record conducted by two survey teams in each of the 5 States. The evaluation results have been very positive; the QIS is very likely to replace the current survey. However, it has not been subject to a summative evaluation: how well the QIS meets the objectives of improving the current survey within the current survey budget is unknown. A contract modification was awarded in August 2006 will provide funds for the second, summative phase of the evaluation's field work. The very substantial variation in deficiency citation rates and scope and severity determinations between States, within States, and from year-to-year has been widely noted as evidence of inconsistency in the survey. A corollary perception is that this inconsistency indicates that the survey is not accurate. Of course, providers tend to view the inconsistency and inaccuracy as evidence that the survey process is capricious and citation rates are too high. In contrast, this inconsistency is viewed by the advocates as evidence that survey agencies are too lax and more enforcement is needed. In either case, confidence in the survey is undermined. The project is now complete.

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

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

Increasing Access to Health Care for Bucks County Residents

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

Status: Supplemental funds were awarded to fund the project through September 2008. In order to use the remaining funds, which were unexpended in 2008 due to local agency matching for portions of grant funds, the grantee requested and was granted another no-cost extension until September 9, 2009.

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

Indiana Disaster Relief

Project No: 11-W-00240/05
Project Officer: Juliana Sharp
Period: August 2008 to August 2009
Funding: $ 0.00
Principal Investigator: Jeffery Wells
Award: Waiver-Only Project
Awardee: Indiana, Family and Social Services Administration
403 W. Washington Street, Room W382
Indianapolis, IN 46204-2740

Status: The demonstration will end on July 31, 2009, by which time all affected individuals must have had a redetermination of their eligibility for Medicaid or SCHIP.

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

Informatics for Diabetes Education and Telemedicine Demonstration (IDEATel)

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

Status: In Phase I of the demonstration, the first 9 months of the project were devoted to technical implementation, field testing, personnel training, and development of the evaluation instruments and procedures. After enrollment began and recruitment was completed, approximately 1,665 beneficiaries were

enrolled and randomized. Overall acceptability of the home telemedicine unit among participants was positive. During Phase II, second and third generation HTUs were developed, tested, and initial deployment begun to install them in the homes of participants. The intervention ended for participants on February 27, 2007. The experience to date indicates that large-scale home telemedicine as a strategy for disease management is technically feasible, can be performed in a fashion that meets current requirements for health care data security and the Health Insurance Portability and Accountability Act and is acceptable to those who agree to participate. Regardless, this does not preclude the extent of training and reinforcement often necessary under these circumstances to elevate enrollees to an active and participatory level. Evidence does indicate that some Medicare beneficiaries living in federally designated medically underserved areas, for reasons such as language barriers, lack of education, and various other socioeconomic indications, are unable or unwilling to use computers or the World Wide Web to obtain health care information and health care services.

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

Inpatient Rehabilitation Facility Classification System Analytic and Programming Support

Project No: HHSM-500-2006-00039C
Project Officer: Susanne Seagrave
Period: September 2006 to September 2009
Funding: $419,840.00
Principal Investigator: David Malitz
Award: Contract
Awardee: Stepwise Systems
P.O. Box 4358
Austin, TX 78765

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

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

Integrated Payment Option Support Contract

Project No: 500-00-0024/06
Project Officer: Juliana Tiongson
Period: September 2002 to March 2009
Funding: $658,775.00
Principal Investigator: Gregory Pope
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: Several tasks under this contract were postponed and/or delayed. The contractor concentrated on the

task of developing a Post Acute Integrated Payment demonstration to be implemeted in the Mercy Medical network of post acute providers in Alabama. The system covered services provided in inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies. The contractor completed all tasks associated with the Post Acute Integrated Payment demonstration and provided some support for the Acute Care Episode Demonstration (ACE).

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

Iowa Community Integration (ICI) Project

Project No: 1C0CMS030272/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $286,899.00
Principal Investigator: Ann Sexton
Award: Grant
Awardee: Mosaic
7925 SE 32nd Avenue
Runnells, IA 50237

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The main objective of the Iowa Community Integration Project is to create and implement a successfully demonstrated model that will support outplacement and community integration of individuals with developmental disabilities who are currently institutionalized at the Glenwood and Woodward Resource Centers in Iowa. ■

Iowa Disaster Relief

Project No: 11-W-00239/07
Project Officer: Juliana Sharp
Period: July 2008 to August 2009
Funding: $ 0.00
Principal Investigator: Jennifer Vermeer
Award: Waiver-Only Project
Awardee: Iowa Medicaid Enterprise, Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: The demonstration will end on August 31, 2009, by which time all affected individuals must have had a redetermination of their eligibility for Medicaid or SCHIP. A Draft Final Report on the demonstration must be delivered to CMS by December 31, 2009.

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

Iowa Family Planning

Project No: 11-W-00188/7
Project Officer: Lane Terwilliger
Period: January 2006 to January 2011
Funding: $ 0.00
Principal Investigator: Jennifer Vermeer
Award: Waiver-Only Project

Awardee: Iowa Medicaid Enterprise,
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: As of6/1/2008, 25,000 individuals received family planning services through the demonstration.

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

IowaCare

Project No: 11-W-00189/07
Project Officer: Juliana Sharp
Period: July 2005 to
June 2010
Funding: $ 0.00
Principal Investigator: Jennifer Vermeer
Award: Waiver-Only Project
Awardee: Iowa Medicaid Enterprise,
Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Status: The Demonstration is fully implemented. As of November 30, 2008, 26,793 expansion eligibles were served under the Demonstration.

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

Kentucky Health Care Partnership Program

Project No: 11-W-00060/04
Project Officer: Mark Pahl
Period: December 1993 to
October 2011
Funding: $ 0.00
Principal Investigator: Elizabeth Johnson
Award: Waiver-Only Project
Awardee: Kentucky Department for Medicaid Services
275 East Main Street, 6 West A
Frankfort, KY 40621

Status: On October 30, 2008, the State was awarded a 3 year extension of the Partnership demonstration.

Description: The Kentucky Health Care Partnership is a sub-state demonstration that uses a single managed care plan model, including public and private providers, to deliver health care. The Partnership is a private non-profit entity that provides services for Medicaid beneficiaries in the city of Louisville in Jefferson County and the fifteen surrounding counties. All non-institutionalized Medicaid beneficiaries are enrolled in the demonstration. Beneficiaries receive a comprehensive benefit package that corresponds to benefits and services available under the Medicaid State plan. Any willing provider may participate in the Partnership plan. The primary objective of the demonstration is to improve access to health care and needed services for beneficiaries, and to test the feasibility of providing services through a single managed care entity. ■

Legal Representation - Arbitration Hearings (Home Health TPL)

Project No: HHSM-500-2006-00047C
Project Officer: Juliana Tiongson
Period: September 2006 to
September 2009
Funding: $1,175,487.00
Principal Investigator: Arthur Bruegger
Award: Contract
Awardee: Blue Cross/Blue Shield Association
225 N. Michigan Avenue
Chicago, IL 60601

Status: The period of performance has been extended to September 2009.

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

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

Project No: HHSM-500-2004-00003I/06
Project Officer: Ronald Deacon
Period: March 2005 to March 2009
Funding: $207,199.00
Award: Task Order
Awardee: Destiny Management Services, LLC
8720 Georgia Avenue
Silver Spring, MD 20910

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

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

Long Term Care Hospital Payment System Refinement/Evaluation

Project No: 500-00-0024/20
Project Officer: Judith Richter
Period: September 2004 to December 2008
Funding: $931,021.00
Principal Investigator: Barbara Gage
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

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

Louisiana Family Planning

Project No: 11-W-00232/6
Project Officer: Lane Terwilliger
Period: June 2006 to August 2011
Funding: $ 0.00
Principal Investigator: Jerry Phillips
Award: Waiver-Only Project
Awardee: Louisiana, Department of Health and Hospitals
628 North 4th Street, P. O. Box 91030
Baton Rouge, LA 70821-9030

Status: As of 10/31/2008, 52,604 individuals received family planning services through the demonstration.

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

Low Vision Rehabilitation Demonstration

Project No: ORDI-05-0002
Project Officer: James Coan
Period: April 2006 to March 2011
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

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

Maine Care for Childless Adults

Project No: 11-W-00158/01
Project Officer: Jacqueline Roche
Period: September 2002 to September 2010
Funding: $ 0.00
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Maine, Department of Human Services
11 State House Station
Augusta, ME 04333

Status: As of September 30, 2008, 12,620 childless adults received coverage under this Demonstration.

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

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

Project No: 11-W-00128/01
Project Officer: Jacqueline Roche
Period: February 2000 to June 2010
Funding: $ 0.00
Principal Investigator: Tony Marple
Award: Waiver-Only Project
Awardee: Office of MaineCare Services (OMS)
11 State House Station
Augusta, ME 04333-0011

Status: As of 6/30/2008, approximately half of the 558 total participants were Medicaid eligibles receiving enhanced care management services, while the rest were expansion eligibles who receive all of their coverage through the Demonstration.

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

Maintain Independence and Employment Demonstration - Mississippi

Project No: 11-P-91175/04
Project Officer: Stephen Hrybyk
Period: October 2000 to December 2007
Funding: $500,000.00
Principal Investigator: Bo Bowen
Award: Grant
Awardee: Mississippi, Office of Governor, Division of Medicaid
Robert E. Lee Building, 239 N. Lamar St., Suite 801,Hinds County
Jackson, MS 39201

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

Description: The Demonstration to Maintain Independence and Employment (DMIE) was created by section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The demonstration allows States to provide medical assistance and other support services to people with potentially severe disabilities who are at risk of becoming disabled and eligible for cash assistance from the Social Security Administration. The Mississippi Project uses the grant award, in conjunction with State funds, to cover persons with HIV/AIDS who work or are willing to return to work. Full Medicaid benefits and services, as well as case management, is provided to the demonstration participants to ensure that they have access and coverage for medical, mental, and social support services necessary to maintain employment and their quality of life. The demonstration site is in nine counties in the Mississippi Delta where there is a relatively high rate of HIV/AIDS, and limited health care resources for people with HIV/AIDS. ■

Maryland Medicaid Section 1115 Health Care Reform Demonstration - HealthChoice

Project No: 11-W-00099/03
Project Officer: Diane Gerrits
Edward Hutton
Period: October 1996 to June 2011
Funding: $ 0.00
Principal Investigator: John Folkemer
Award: Waiver-Only Project
Awardee: Maryland, Department of Health and Mental Hygiene
201 W. Preston Street, Room 525
Baltimore, MD 21201

Status: The State extended the demonstration until 2011.

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

MassHealth: Massachusetts Health Reform Demonstration

Project No: 11-W-00030/01
Project Officer: Jacqueline Roche
Period: April 1995 to June 2011
Funding: $ 0.00
Principal Investigator: Tom Dehner
Award: Waiver-Only Project
Awardee: Commonwealth of Massachusetts, Division of Medical Assistance
One Ashburton Place, 11th Floor
Boston, MA 02108

Status: The Mass Health Demonstration was approved on December 22, 2008 for another three year extension period through June 30th 2011. The Demonstration is entering its twelve year and covers more than one million low-income individuals across the Commonwealth, including more than 200,000 newly enrolled individuals following the enactment of a near-universal coverage initiative in 2006.

Description: The MassHealth section 1115(a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The initial MassHealth demonstration was approved in 1997 to enroll most Medicaid recipients into managed care organizations (Medicaid managed care program). Unique features of the Demonstration include the Insurance Partnership (IP) Program and the Safety Net Care Pool. The IP program is an employer sponsored insurance (ESI) program, which provides a subsidy for employers with 50 or fewer employees as long as the employer contributes at least 50 percent of the total premium for the employee and any dependents. In addition to managed care savings, funds formerly used to make payment adjustments to disproportionate share hospitals (DSH) also are used to provide health care coverage. On April 12, 2006, the State adopted legislation designed to provide access to affordable health insurance coverage to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006, titled An Act Providing Access to Affordable, Quality, Accountable Health Care (Act), builds upon the MassHealth section 1115 demonstration extension approved by CMS on January 26, 2005, which established the Safety Net Care Pool (SNCP). The Act accomplishes several goals of the negotiated demonstration extension including: improving the fiscal integrity of the MassHealth program, directing more federal and state health dollars to individuals and less to institutions, and subsidizing the purchase of private insurance for low-income individuals to reduce the number of uninsured in the Commonwealth. ■

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

Project No: 500-00-0032/13
Project Officer: Suzanne Rotwein
Period: July 2005 to July 2009
Funding: $2,288,389.00
Principal Investigator: Andrea Hassol
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Abt will continue investigating state of the art business models for achieving collaborative partnerships and determining, through actionable research, how CMS can structure similar initiatives. The period of performance was extended to July 2009.

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

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

Project No: 500-00-0047/06
Project Officer: Susan Radke
Period: September 2005 to September 2009
Funding: $1,709,149.00
Principal Investigator: Suzanne Dodds
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has completed development of MAX data for 2004. Work is well under way on MAX data for year 2005, and most data files are completed. Year 2005 data will be available to the user community by late 2008 or early 2009.

Description: The purpose of this task order is to have Medicaid eligibility and services claims experts to develop business "rules" to transform Medicaid (and SCHIP) person-level data records from the Medicaid Statistical Information System (MSIS) into records in the Medicaid Analytic eXtract (MAX) system. These business rules involve a number of activities related to eligibility, type of service and combination of MSIS claims to create MAX final action service records. This involves reviewing MSIS documentation, developing MSIS to MAX business "rules", possible interaction wtih State Medicaid agency personnel to gather information, clarify issues and/or devise corrective action strategies.

The contractor passes the business "rules" to another party, known here as the MAX producer, who processes the MSIS files according to the MAX business rules to create the MAX data files. Once the MAX producer develops MAX data, this contractor performs a comprehensive assessment of data quality and validity to assure that the final MAX data are of the highest possible quality. The validation process may involve a number of iterations between the MAX producer and the contractor until data quality issues are resolved. Upon acceptance of the final MAX data files, the contractor assists the Federal project officer to prepare the data for access by the user community which includes CMS, other HHS components, other Federal and State agencies, foundations, consulting firms, and academic institutions. This includes preparation of explanatory materials on the business rules, data validation reports, data anomaly reports and limited technical consultation on data issues. Interested parties may obtain additional information at the CMS MAX Web site: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp#TopOfPage ■

Medicaid Infrastructure Grants - States A to M

Project No:	2008-MIG-AM
Project Officer:	Effie George Joseph Razes
Period:	October 2000 to December 2008
Funding:	$101,735,190.00
Award:	Grant
Awardee:	See Status The awardees are included in the status. ,

Status: Here is the status of each of the 2008 Medicare Infrastructure Grants sorted in alphabetical order from letter A to M: State: Alabama (Y2) Grant Number: 1QACMS030229/01 Awardee: Alabama Department of Rehabilitation Services Annual Funding: $500,000 Project Investigator: Karen Coffey State: Alaska (Y1) Grant Number: Awardee: Alaska Governor's Council on Disabilities & Special Education Annual Funding: $750,000 Project Investigator: Millie Ryan State: Arizona (Y3) Grant Number: 1QACMS300122/02 Awardee: Arizona Health Care Cost Containment System Annual Funding: $750,000 Project Investigator: Dara Johnson State: Arkansas (Y2) Grant Number: 1QACMSS030230 Awardee: Arkansas Department of Human Services Annual Funding: $682,000 Project Investigator: Scott Holladay State: California (Y1) Grant Number: Awardee: San Diego State University Research Foundation Annual Funding: $2,640,006 Project Investigator: Eugene Stein State: Connecticut (Y4) Grant Number: 1QACMS30050 Awardee: Connecticut Department of Social Services Annual Funding: $4,631,665 Project Investigator: Amy Porter State: District of Columbia (Y3) Grant Number: 1QACMS300125/02 Awardee: District of Columbia, Department of Health Annual Funding: $750,000 Project Investigator: Allen Jensen State: Florida (Y2) Grant Number: 1QACMS3000051/01 Awardee: Florida Agency for Persons with Disabilities Annual Funding: $750,000 Project Investigator: John Bartow Black State: Hawaii (Y3) Grant Number: 1QACMS300120/01 Awardee: University of Hawaii College of Education Annual Funding: $750,000 Project Investigator: Susan Miller State: Idaho (Y1) Grant Number: Awardee: Idaho State Independent Living Council Annual Funding: $500,000 Project Investigator: Jim Liddell State: Illinois (Y3) Grant Number: 1QACMS300121 Awardee: Ilinois Department of Healthcare and Family Services Annual Funding: $500,000 Project Investigator: Sandra Mott State: Indiana (Y2) Grant Number: 1QACMS030232 Awardee: Indiana Family & Social Services Administration Annual Funding: $750,000 Project Investigator: Theresa Koleszar State: Iowa (Y2) Grant Number: 1QACMS030233/01 Awardee: Iowa Department of Human Services Annual Funding: $744,000 Project Investigator: Jennifer Steenblock State: Kansas (Y3) Grant Number: 1QACMS300127 Awardee: Kansas Health Policy Authority Annual Funding: $750,000 Project Investigator: Mary Ellen O'Brien Wright State: Louisiana (Y4) Grant Number: 1QACMS300052/03 Awardee: Louisiana State Department of Health & Hospitals Annual Funding: $750,000 Project Investigator: Elaine Richard State: Maine (Y1) Grant Number: Awardee: State of Maine Department of Health & Human Services Annual Funding: $750,000 Project Investigator: Kathy Bubar State: Maryland (Y3) Grant Number: 1QACMS300119/02 Awardee: Maryland Department of Disabilities Annual Funding: $600,000 Project Investigator: Jade Gingerich State: Massachusetts (Y2) Grant Number: 1QACMS030234 Awardee: University of Massachusetts Medical School Annual Funding: $5,600,409 Project Investigator: Shelley Stark State: Michigan (Y3) Grant Number: 1QACMS300124/02 Awardee: Michigan Department of Community Health Annual Funding: $750000 Project Investigator: Michael Head State: Minnesota (Y1) Grant Number: Awardee: Minnesota Department of Human Services Annual Funding: $5,434,648 Project Investigator: MaryAlice Mowry State: Montana (Y1) Grant Number: Awardee: Montana Department of Public Health & Human Services Annual Funding: $750,000 Project Investigator: Barbara Kriskovich

Description: The Medicaid Infrastructure Grant Program is authorized under Section 203 of the Ticket-

to-Work and Work Incentives Improvement Act. The 11-year competitive grant program provides funding to States for Medicaid infrastructure development that will build supports for people with disabilities who would like to be employed. States are encouraged to use grant funding to implement and develop the optional working disabled eligibility group (Medicaid buy-in), increase the availability of statewide personal assistance services, form linkages with other State and local agencies that provide employment related supports, and create a seamless infrastructure that will maximize the employment potential of all people with disabilities. For additional information concerning the Medicaid Infrastructure Grant Program, please visit our Web site at www.cms.hhs.gov/twwiia. ■

Medicaid Infrastructure Grants - States N to W

Project No: 2008-MIG-NW
Project Officer: Effie George
Joseph Razes
Period: October 2000 to December 2008
Funding: $101,735,190.00
Award: Grant
Awardee: See Status
The awardees are included in the status.
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Status: Here is the status of each of the 2008 Medicare Infrastructure Grants sorted in alphabetical order from letter N to W: State: Nebraska (Y5, NCE) Grant Number: 11-P-92404/7-04 Awardee: Nebraska Department of Health & Human Services System Annual Funding: n/a Project Investigator: Sharon Johnson State: Nevada (Y1) Grant Number: Awardee: Nevada Department of Health & Human Services Annual Funding: $500,000 Project Investigator: Constance Anderson State: New Hampshire (Y3) Grant Number: 1QACMS300123 Awardee: New Hampshire Department of Health & Human Services Annual Funding: $1,480,863 Project Investigator: Denise St. Onge State: New Jersey (Y3) Grant Number: 1QACMS300118/02 Awardee: New Jersey Department of Human Services Annual Funding: $500,000 Project Investigator: William Ditto State: New Mexico (Y1) Grant Number: Awardee: New Mexico Human Services Department Annual Funding: $1,592,000 Project Investigator: Ernesto Rodriguez State: New York (Y1) Grant Number: Awardee: New York State Office of Mental Health Annual Funding: $5,992,413 Project Investigator: John Allen State: North Carolina (Y1) Grant Number: Awardee: North Carolina Department of Health & Human Services Annual Funding: $600,000 Project Investigator: Wayne Howell State: North Dakota (Y3) Grant Number: 1QACMS300054-03 Awardee: Minot State University Annual Funding: $750,000 Project Investigator: Tom Alexander State: Ohio (Y2) Grant Number: 1QACMS030235/01 Awardee: Ohio Department of MRDD Annual Funding: $500,000 Project Investigator: Leslie Paull State: Oregon (Y1) Grant Number: Awardee: Oregon Department of Human Services Annual Funding: $750,000 Project Investigator: Sara Kendall State: Pennsylvania (Y1) Grant Number: Awardee: Bureau of Policy Annual Funding: $5,327,141 Project Investigator: Trudy Johnson State: Rhode Island (Y1) Grant Number: Awardee: University of Rhode Island Annual Funding: $750,000 Project Investigator: Elaina Goldstein State: South Dakota (Y4) Grant Number: 1QACMS300057 Awardee: South Dakota Department of Human Services Annual Funding: $500,000 Project Investigator: Grady Kickul State: Texas (Y2) Grant Number: 1QACMS0301361/01 Awardee: Texas Department of Assistive & Rehabilitative Services Annual Funding: $750,000 Project Investigator: Lynn Blackmore State: Utah (Y1) Grant Number: Awardee: Utah Department of Health Annual Funding: $750,000 Project Investigator: Carol Ruddell State: Vermont (Y1) Grant Number: Awardee: Disabilities, Aging and Independent Living Annual Funding: $750,000 Project Investigator: Susan Wells State: Virginia (Y2) Grant Number: 1QACMS030237 Awardee: Virginia Department of Medical Assistance Services Annual Funding: $750,000 Project Investigator: Jack Quigley State: Washington (Y1) Grant Number: Awardee: Washington State Department of Social & Health Services Annual Funding: $750,000 Project Investigator: Manning Pellanda State: West Virginia (Y4) Grant Number: 1QACMS30059 Awardee: West Virginia Department of Education & the Arts Annual Funding: $750,000 Project Investigator: Deborah Lovely State: Wisconsin (Y1) Grant Number: Awardee: Wisconsin Department of Health & Family Services Annual Funding: $9,881,187 Project Investigator: John Reiser State: Wyoming (Y3) Grant Number: 1QACMS300126/01 Awardee: University of Wyoming College of Health Sciences Annual Funding: $750,000 Project Investigator: David Schaad

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

create a seamless infrastructure that will maximize the employment potential of all people with disabilities. For additional information concerning the Medicaid Infrastructure Grant Program, please visit our Web site at www.cms.hhs.gov/twwiia. ■

Medicaid Statistical Information System (MSIS)Data Quality Support

Project No: HHSM-500-2005-00025I/0009
Project Officer: Denise Franz
Period: September 2008 to September 2009
Funding: $1,186,825.00
Principal Investigator: Suzanne Dodds
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research (Cambridge)
50 Church Street
Cambridge, MA 02138-3726

Status: Mathematica continues to peform technical support for the quality of State-submitted MSIS data by performing validation reviews of these data. They continue to work with States to improve the ongoing quality of their MSIS data submissions, addressing coding and data definition issues. In addition the contractor works with States to improve the quality of their MMA data. The work on this project is ongoing. The contract was reawarded to MPR in September 2008 and includes to option years after FY 2009.

Description: The contractor will provide technical support to States as States submit and eligibility and 4 claims files quarterly through the Medicaid Statistical Information System (MSIS). The contractor will use validation tools to analyze the quality of each data file aand provide feedback tables to CMS and the States. The contractor will also support the analysis of Medicaid data and work directly with States to isolate root causes of quality problems and identify possible solutions. The contractor will also work with States as they submit monthly dual-eligible data to CMS as required in the Medicare Modernization Act of 2003 (MMA). The contractor will use validation tool to analyze the data and provide feedback tables to CMS and the States. ■

Medical Adult Day-Care Services Demonstration

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

Status: Proposals from potential applicants were solicited through a notice published in the Federal Register on June 24, 2005 with applications due on September 24, 2005. Final site selection was completed May 2006. Implementation of the demonstration began August 1, 2006. The five sites are: Aurora Visiting Nurses Association, Milwaukee, Wisconsin; Doctor's Care Home Health, McAllen, Texas; Landmark Home Health Care Services, Allison Park, Pennsylvania; Metropolitan Jewish Health System, Brooklyn, New York; and Neighborly Care Network, St. Petersburg, Florida. In 2008, the Brooklyn and Milwaukee sites withdrew from the demonstration. Abt Associates, as the support contractor, will continue to assist CMS in the management and monitoring of the demonstration sites through July 2009.

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

Medical Home Demonstration Design Contract

Project No: HHSM-500-2005-00025I/05
Project Officer: James Coan
Period: September 2007 to April 2009
Funding: $333,781.00
Principal Investigator: Deborah Peikes
Award: Task Order
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The contractor has prepared 6 option papers defining the components of medical home, patient and practice eligibility requirements, payment methodology, shared savings calculation methodology, site selection, and recruitment and monitoring of physician practices. Final demonstration design was submitted in June 2008. Currently, CMS is awaiting final Departmental and OMB approval.

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

Medical Home Demonstration Implementation

Project No: HHSM-500-2005-00026I/01
Project Officer: James Coan
Period: September 2008 to September 2013
Funding: $2,849,193.00
Principal Investigator: A Weiss
Award: Task Order (MRAD)
Awardee: Thomson Reuters (Healthcare), Inc.
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111-5888

Status: This contract was awarded September 30, 2008. Currently, the contractor is developing necessary infrastructure to conduct recruitment, application and qualification processes for eligible physician-based practices. Recruitment is expected to begin in March 2009. The application and qualification process will begin April and end in November 2009. Implementation of the demonstration intervention is scheduled to begin in January 2010.

Description: The CMS plans to conduct a Medical Home Demonstration as directed by Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA). The Act calls for the project to provide targeted, accessible, continuous and coordinated family-centered care to high-need populations through a Medical Home demonstration. The Act also specifies that the Demonstration will include Medicare beneficiaries who are deemed to be "high-need" (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.) The Medical Home Demonstration will be conducted in up to 8 states including urban, rural and underserved areas, over a 3-year period. CMS will identify the demonstration locales in early 2009. The Implementation Contractor shall identify, recruit and register interested physician practices within demonstration locales (not yet determined) to participate in the Medical Home Demonstration, and to enroll beneficiary participants into Medical Homes by collecting beneficiary Agreement/ Acceptance forms submitterd by Medical Homes. The Implementation Contractor will be responsible for applying risk adjustment methodology to the list of beneficiary participants to determine the appropriate monthly Medical Home fee to be paid. Additionally, the Implementation Contractor will conduct the process to recognize qualified physician practices as Medical Home practices and determine their appropriate Medical Home tier at the beginning of the demonstration and also upon request of a practice seeking to qualify for a higher Medical Home tier. The Implementation Contractor will coordinate with the Medical Home Payment Contractor by transmitting files of recognized Medical Home practices and their tier, transmitting files of personal physicians and the Medical Home they are affiliated with, and transmitting risk adjusted files of beneficiary participants. Recruitment of physician practices is expected to begin in March 2009. Payment of monthly Medical Home fees will begin January, 2010. The Implementation Contractor will monitor participating practices to assure the Medical Home model is being appropriately implemented. ■

Medi-Cal Hospital Uninsured Care

Project No: 11-W-00193/09
Project Officer: Steven Rubio
Period: August 2005 to August 2010
Funding: $ 0.00
Principal Investigator: Toby Douglas
Award: Waiver-Only Project
Awardee: California, Department of Health Services
1501 Capitol Avenue, Suite 71.6086, MS 4000, PO Box 942732
Sacramento, CA 94234-7320

Status: CMS approved the State's amendment request to enable the State to develop and implement the Coverage Initiative. The amount of funding available for the Coverage Initiative is $180 million annually in SNCP funding for Demonstration Years 3 through 5. During 2008 the State began implementation of the Coverage Inititive in 10 counties.

Description: to expansion of Medicaid managed care for ABD populations (Demonstration Years 1 and 2) and implementation of a Coverage Initiative for the uninsured (Demonstration Years 3 through 5). The State did not meet the requirements spelled out for Years 1 and 2. The following are the guiding principles that were used to provide the framework for the Coverage Initiative (CI): · Use of organized delivery systems to manage the care of the uninsured; · Promotion of the use of preventive services and early intervention; · Promotion of personal responsibility for service utilization; · The CI is not an entitlement program for the State, beneficiaries, or participating providers; · Cover uninsured individuals who have no eligibility for Medi-Cal or Healthy Families; and · Develop the CI in a manner to ensure long term viability within existing safety net health care systems. The principle activity under this Demonstration is the reimbursement of providers for the uncompensated cost of care for the uninsured. ■

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

Project No: HHSM-500-2005-00029I/10
Project Officer: Cynthia Mason
Period: September 2007 to September 2012
Funding: $1,199,765.00
Principal Investigator: Nancy McCall
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

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

Medicare Chronic Care Practice Research Network

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

Status: The grant was awarded in July 2008 and the Medicare Chronic Care Research Practice Network has obtained a contractor to perform some analysis regarding care coordination interventions and strategies. The Network has also held conferences with national experts to brainstorm on new interventions that could be useful in the chronically ill Medicare population.

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

Medicare Contractor Provider Satisfaction Survey (MCPSS)

Project No: 500-01-0020/04
Project Officer: Teresa Mundell
Gladys Valentin
Period: September 2004 to September 2009
Funding: $4,817,250.00
Principal Investigator: Vasudha Narayanan
Award: Task Order (ADDSTO)
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: The MCPSS 5-year contract will expire September 29, 2009.

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

Medicare Current Beneficiary Survey

Project No: 500-2004-00006C
Project Officer: Franklin Eppig
Period: February 2004 to February 2009
Funding: $71,651,917.00
Principal Investigator: Richard Apodaca
Award: Contract
Awardee: Westat Corporation
1650 Research Boulevard
Rockville, MD 20850

Status: The MCBS has been in the field continuously since Fall 1991. It is currently in its 52nd round of interviewing. To date, public use data files are available for 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005 and 2006.

Description: The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid CMS's administration, monitoring, and evaluation of the Medicare Program. The survey is focused on health care use, cost, and sources of payment. Data from the MCBS will enable CMS to: • Determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and noncovered services. • Develop reliable and current information on the use and cost of services not covered by Medicare (e.g., long-term care). • Ascertain all types of health-insurance coverage and relate coverage to sources of payment. • Monitor the financial effects of changes in the Medicare Program. Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services. ■

Medicare Grouper Evaluation and Physician Profiling Issues

Project No: HHSM-500-2006-00006I/14
Project Officer: Fred Thomas
Period: August 2008 to November 2009
Funding: $699,993.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The project is underway.

Description: During a recent GAO study it was found that there is substantial cost variation across patients within disease types using annual claims data. An extension of this work is that physician profiles may be generated from claims data to identfy those responsible for higher care costs, and then use financial incentives to change this behavior. In light of the continuing policy debate, and to test the application of these concepts in Medicare, CMS desired a contractor to continue the

work performed under the Episodic Grouper Evaluation contract. ■

Medicare Lifestyle Modification Program Demonstration Evaluation

Project No: 500-95-0060/02
Project Officer: Kathleen Connors de laguna
Period: September 2000 to September 2008
Funding: $4,197,730.00
Principal Investigator: Donald Shepard
William B. Stason
Roxanne Rodgers
Award: Task Order
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: Early in the contract, the evaluation was expanded to include a longer follow-up period of treatment and control patients, and to include a critical review of literature of all lifestyle modification programs worldwide. Following the implementation of new enrollment criteria, the contract was expanded to include another matched control group of beneficiaries that have had cardiac rehabilitation as part of traditional treatment. In addition, the evaluation was expanded to include a study of the Medicare cardiac rehabilitation benefit. The contractor is completing work on the evaluation and we expect to have the final report in early 2009.

Description: This project evaluates the health outcomes and cost effectiveness of the Medicare Lifestyle Modification Program Demonstration for Medicare beneficiaries with coronary artery disease (CAD). The demonstration tests the feasibility and cost effectiveness of providing payment for cardiovascular lifestyle modification program services to Medicare beneficiaries. The goal of the evaluation is to provide an assessment of the health benefit and cost-effectiveness of treatment for Medicare beneficiaries with CAD who enroll in the 12-month long cardiovascular lifestyle modification programs at the demonstration sites. The evaluation of the demonstration assesses the overall performance of the demonstration sites, including the quality of health care delivery over the course of the demonstration period. The evaluation also assesses the use of systems for administration, claims processing and payment, and the routine monitoring of quality of care. The evaluation consists, in part, of a pre/post quasi-experimental, matched pairs design with a 1-year follow-up of a maximum of 3,600 treatment enrollees and 3,600 comparison group subjects. Data collection included diagnostic and clinical outcome information from treatment and control patient physicians and the treatment program, supplemented by medical record review, patient surveys, program case studies, and Medicare claims data. Allowances were made to provide an incentive payment to the patients' physician for information reporting. ■

Medicare Lifestyle Modification Program Demonstration: Quality Monitoring and Review

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

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

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

contracted with the Delmarva Foundation for Medical Care, Inc. to provide continuous quality monitoring of the demonstration sites to assure the health and safety of participating Medicare patients. ■

Medicare Part D Program Evaluation

Project No: HHSM-500-2005-00029I/09
Project Officer: Aman Bhandari
Period: September 2007 to December 2010
Funding: $658,191.00
Principal Investigator: Mel Ingber
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The research is ongoing and first report is expected in Fall 2009.

Description: The purpose of this evaluation is to examine the impact of the Part D benefit on the broader Medicare Program as well as its impact on sub-populations of beneficiaries. To accomplish its purpose, the study is divided into three separate components. The first component is an analysis of the impact of the Part D benefit on the traditional Medicare program. The other two components involve an analysis of the impact of the Part D benefit on the Medicare Advantage program and an anlysis of the impact of the Medicare Part D benefit on beneficiaries with chronic conditions. ■

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

Project No: HHSM-500-2006-00006I/12
Project Officer: Craig Dobyski
Period: March 2008 to March 2009
Funding: $182,510.00
Principal Investigator: Margaret O'Brien-Strain
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The contractor has completed a draft report.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order - Mathematica Policy Research

Project No: HHSM-500-2005-00025I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: This contract is an umbrella contract and is in its third year. There are currently twelve (12) task orders awarded under the contract.

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

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

Project No: HHSM-500-2005-000311
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base

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

Status: This is an umbrella contract and is in it third year. There is currently one (1) task order awarded under this contract.

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

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

Project No: HHSM-500-2005-00023I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: JEN Associates, Inc.
P.O. Box 39020
Cambridge, MA 02139

Status: This is an umbrella contract and is in its third year. There are no active task orders awarded under this contract.

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

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

Project No: HHSM-500-2005-00024I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church,VA 22042

Status: This is an umbrella contract and is in its third year. Currently there are three (3) task orders awarded under this contract.

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

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

Project No: HHSM-500-2005-00026I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

Status: This is an umbrella contract and is in its third year. Currently, there is one active task order awarded under this contract.

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

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

Project No: HHSM-500-2005-00028I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: This is an umbrella contract and is in its third year. Currently there are three (3) task orders awarded under this contract.

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

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

Project No: HHSM-500-2005-00029I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This is an umbrella contract, and is in its third year. Currently there are sixteen (16) task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - University of Minnesota

Project No: HHSM-500-2005-00027I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: This is an umbrella contract and is currently in its third year. Currently there are four (4) task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contract - University of Wisconsin

Project No: HHSM-500-2005-00032I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: University of Wisconsin - Madison
750 University Avenue
Madison, WI 53706

Status: This is an umbrella contract and is in its third year. Currently there are no active task orders awarded under this contract.

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

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

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

Status: This is an umbrella contract and is in it third year. Currently there are no active task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - Abt

Project No: HHSM-500-2005-00018I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Task Order Contract, Base
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: This is an umbrella contract and is in its third year. Currently there are five (5) task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - American Institute for Research (AIR)

Project No: HHSM-500-2005-00019I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: American Institute for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007-3835

Status: This is an umbrella contract and is in its third year. Currently there are two (2) task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - Brandeis University

Project No: HHSM-500-2005-00020I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
415 South Street, P.O. Box 9110
Waltham, MA 02254-9110

Status: This is an umbrella contract and is in its third year. Currently there are three (3) task orders awarded under this contract.

Description: The MRAD/TOC contractor will be required to conduct general research, analysis, demonstration, evaluation and survey activities relating to Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), in addition to other CMS

program responsibilities. Individual projects will be initiated through award of specific task orders. ■

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - CNA

Project No: HHSM-500-2005-000211
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: C.N.A. Corporation
4825 Mark Center Drive
Alexandria, VA 22311-1850

Status: This is an umbrella contract and is in its third year. Currently there are no active task orders awarded under this contract.

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

Medicare/Medicaid Research and Demonstration (MRAD) Task Order Contracts - University of Colorado, CHPR

Project No: HHSM-500-2005-00022I
Project Officer: Leslie Mangels
Period: September 2005 to September 2010
Funding: $ 1,000.00
Award: Master Contract, Base
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: This is an umbrella award and is in its third year. Currently there are two (2) task orders awarded under this contract.

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

MEDS-AD

Project No: 11-W-00205/04
Project Officer: Mark Pahl
Period: December 2005 to December 2010
Funding: $ 0.00
Principal Investigator: Carlton Snipes
Award: Waiver-Only Project
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
2727 Mahan Drive, Mail Stop 8
Tallahasee, FL 32308

Status: The Florida MEDS-AD demonstration was implemented January 1, 2006, and will run through December 31, 2010.

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

Mercy Medical Skilled Nursing Home Payment Demonstration

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

Status: This pilot project will end December 31, 2008 at which time Mercy Medical will be paid via SNF PPS. The proposed new demonstration using a bundled payment methodology for post-acute care was not approved for implementation because the intervention was unique to Mercy Medical System and did not appear to be replicable on a national scale.

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

Michigan Family Planning

Project No: 11-W-00215/5
Project Officer: Lane Terwilliger
Period: March 2006 to March 2011
Funding: $ 0.00
Principal Investigator: Paul Reinhart
Award: Waiver-Only Project
Awardee: Michigan Department of Community Health, Medical Services Administration
Capitol Commons Center, 7th Floor, 400 S. Pine Street
Lansing , MI 48909

Status: As of 10/31/2008, 32,202 individuals received family planning services through the demonstration.

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

Minimum Data Set Technical Support Contract

Project No: 500-00-0032/15
Project Officer: Martin Rice
Period: September 2005 to June 2009
Funding: $4,554,875.00
Award: Task Order
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The period of performance has been extended. Optional Phase 3 has been deleted but the Statement of Work has been scaled down because requirements have been changed.

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

Minnesota Family Planning

Project No: 11-W-00183/5
Project Officer: Lane Terwilliger
Period: July 2004 to June 2011
Funding: $ 0.00
Principal Investigator: Christine Bronson
Award: Waiver-Only Project
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0998

Status: As of 9/30/2008, 85,419 individuals received family planning services through the demonstration.

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

Minnesota Prepaid Medical Assistance Project Assistance Plus (PMAP+)

Project No: 11-W-00039/05
Project Officer: Wanda Pigatt-canty
Period: April 1995 to June 2011
Funding: $ 0.00
Principal Investigator: Christine Bronson
Award: Demonstration
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0998

Status: On August 11, 2008 CMS approved the 3 year extension of the demonstration until June 30, 2011. The State requested continued negotiations related to the Medical Education Research and Costs (MERC) Fund and reporting of MinnesotaCare Caretaker Adults with incomes from 100-200% of the FPL who are funded via SCHIP then revert to title XIX. CMS and the State reached final agreement in language revisions which became effective 10/31/2008 through June 30, 2011. Effective February 1, 2009, parents with incomes between 100 and 200% FPL who had been served under the MinnesotaCare Demonstration (21-W-00004/5) will be served under PMAP+.

Description: Prepaid Medical Assistance Project Plus (PMAP+) provides a managed care delivery system to Medicaid eligibles in Minnesota. PMAP is currently enrolling recipients in eighty-three of Minnesota's eighty-seven counties. The PMAP demonstration also provides title XIX matching funds for expansion coverage groups enrolled in MinnesotaCare. The demonstration eligibility expansion includes uninsured pregnant women, infant and children with an income of up to 275 % of the FPL and parents/caretaker relatives with income up to 275% FPL or $50,000 and with assets up to $20,000. MinnesotaCare pregnant women, infants and children receive the full Medicaid benefits; parents and caretaker relatives receive a reduced Medicaid benefit. All of the beneficiaries that are enrolled in Minnesota Care are required to pay premiums on a sliding scale based upon income. In addition, co-payments are required for certain services. ■

Minnesota Senior Health Options/Minnesota Disability Health Options

Project No: 11-W-00024/05
Project Officer: Susan Radke
Period: April 1995 to December 2007
Funding: $ 0.00
Principal Investigator: Pamela Parker
Award: Waiver-Only Project
Awardee: Minnesota, Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0998

Status: This dually eligible demonstration was approved for the period of January 1, 2005 through December 31, 2007. The State contracts with nine health care plans to provide MSHO services. MnDHO was approved to expand the MnDHO eligibility to beneficiaries diagnosed with Mental Retardation and Developmental Disabilities (MR/DD). Further, all nine health plans are currently approved Medicare Advantage Special Needs Plans (MA/SNPs). MSHO/MnDHO transitioned from demonstration status to become full MA/SNPs by January 1, 2008. A new Medicare waiver demonstration that will apply a phase out of the frailty adjustment made to payments to the MA SNP health plans in the State of Minnesota will continue from January 1, 2008 through December 31, 2010.

Description: In April 1995, the State of Minnesota was awarded Medicare and Medicaid waivers for a 5-year demonstration designed to test delivery systems that integrate long-term care and acute-care services for elderly dually eligible beneficiaries. Initially, under this demonstration, the State was being treated as a health plan that contracted with CMS to provide services, and provided those services through subcontracts with three health care plans. CMS approved the State's request in year 2001 to extend MSHO and expand eligibility criteria to include persons under the age of 65 with disabilities. The expansion program, titled "Minnesota Disability Health Options Program"(MnDHO), includes both disabled dually eligible beneficiaries and Medicaid eligible only beneficiaries. Administration of this program is similar to MSHO. Medicare services for MSHO and MnDHO are provided using a demonstration waiver under §402 of the Social Security Amendments of 1967. Medicaid services are provided under §1915(a) and §1915(c) of the Social Security Act. MSHO and MnDHO are managed care products that integrate Medicare and Medicaid financing; acute and long-term care service delivery, including home and community based waiver services for dually eligible and Medicaid

eligible physically disabled adults and elderly in the State of Minnesota. MnDHO was implemented initially in Hennepin, Ramsey, Dakota, and Anoka counties and will expand to three more of the 10 MSHO counties. Enrollment in MSHO and MnDHO is voluntary and available to dually eligible beneficiaries living in institutions, community enrollees who meet institutional placement criteria, and other community enrollees whose needs do not meet institutional levels of care. ■

Mississippi Family Planning

Project No: 11-W-00157/4
Project Officer: Tonya Moore
Period: January 2003 to September 2011
Funding: $ 0.00
Principal Investigator: Robert L. Robinson
Award: Waiver-Only Project
Awardee: State of Mississippi, Division of Medicaid
Walter Sillers Building, Suite 1000, 550 High Street
Jackson , MS 39201-1399

Status: As of 9/30/2008, 54,181 individuals received family planning services through the demonstration.

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

Missouri Family Planning

Project No: 11-W-00236/7
Project Officer: Lane Terwilliger
Period: October 2007 to September 2010
Funding: $ 0.00
Principal Investigator: Karen Lewis
Award: Waiver-Only Project
Awardee: Missouri, Department of Social Services, Division of Medical Services
615 Howerton Court, P.O. Box 6500
Jefferson City , MO 65102

Status: As of 9/30/2008, 21,000 individuals received family planning services through the demonstration.

Description: This demonstration provides family planning services to uninsured postpartum women ages 18 to 55 who lose Medicaid eligibility 60 days after the birth of their child for a maximum of 1 year after their Medicaid eligibility expires. ■

Missouri Managed Care Plus (MC+)

Project No: 11-W-00122/07
Project Officer: Juliana Sharp
Period: April 1998 to October 2007
Funding: $ 0.00
Principal Investigator: Pamela Parker
Award: Waiver-Only Project
Awardee: Missouri, Department of Social Services, Division of Medical Assistance
P.O. Box 6500
Jefferson City, MO 65102-6500

Status: The demonstration expired on October 15, 2007. The populations that were served under the demonstration at the time of expiration included optional targeted low-income children (up to 300 percent of the FPL) and postpartum uninsured women who lose their Medicaid eligibility 60 days after the birth of their child. The optional targeted low-income children transitioned into a combination State Children's Health Insurance Program (SCHIP) program. The postpartum uninsured women transitioned into a separate, stand-alone section 1115 family planning demonstration, entitled Women's Health Services Program.

Description: The demonstration was a statewide program that provided Medicaid Managed Care to adults and children in the State that were not otherwise eligible for Medicaid. The demonstration ran concurrently with the State's current Section 1915(b) waiver, also known as Managed Care Plus (MC+). The demonstration also provided family planning services to postpartum uninsured women who lost their Medicaid eligibility 60 days after the birth of their child. ■

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

Project No: HHSM-500-2005-00027I/01
Project Officer: Karyn Anderson
Period: September 2005 to September 2010
Funding: $881,716.00
Principal Investigator: A. Marshall McBean
Award: Task Order (MRAD)
Awardee: University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Mail Code Number 99
420 Delaware Street SE, D 355 Mayo Building
Minneapolis, MN 55455

Status: The project is in progress. Final drafts of Activities 1 and 2 have been submitted on schedule. Activity 3 will require the use of Part D data and has therefore been delayed until the data is received by the contractor.

Description: The purpose of this contract is to conduct analytic studies designed to better understand the nature of chronic disease among Medicare beneficiaries and to improve the care of these populations. The 723 database and Part D data serve as the data sources for the analytic studies to be conducted under this contract. Activities 1 and 2 of this project found that although diabetes care services decreased, and the odds of dying increased, among those with multiple chronic conditions as compared to diabetes only, the receipt of these diabetes care services was associated with half the odds of dying and lower costs to Medicare. ■

Mystery Shopping

Project No: 500-00-0037/09
Project Officer: Barbara Cohen
Period: August 2005 to December 2007
Funding: $611,222.00
Principal Investigator: Lauren Blatt
Award: Contract
Awardee: Bearing Point
1676 International Drive
McLean,VA 22102-4828

Status: Mystery Shopping for 1-800-MEDICARE ended in February 2006. Mystery Shopping for the SHIP program continued and the project was extended with a no-cost extension to December 31, 2007. The project is now completed.

Description: As part of the National Medicare Education Program (NMEP), the Centers for Medicare and Medicaid Services (CMS) must provide information about Medicare to beneficiaries, caregivers, providers, and partners. Performance assessment plays a critical part of the agency's efforts to provide this information. The Contractor shall provide assistance to CMS in assessing how well we are communicating with our Medicare beneficiaries, caregivers, and providers. With the activity of mystery shopping, emphasis is directed to ability to communicate well with people with Medicare and with caregivers. This Task Order concerns mystery shopping assessments of two NMEP channels: 1-800-MEDICARE and the State Health Insurance Assistance Programs (SHIPSs). ■

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

Project No: 500-00-0048/01
Project Officer: Kathryn King
Period: September 2005 to May 2009
Funding: $973,989.00
Principal Investigator: John Engberg
Award: Task Order (RADSTO)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

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

Description: The purpose of this Task Order is to evaluate the impact of the 10 grants awarded by the Centers for Medicare and Medicaid Services (CMS) under the "Demonstration to Improve the Direct Service

Community Workforce." These grants were awarded to test the effectiveness of the various interventions to improve the recruitment and retention of direct service workers. ■

New Jersey Cash and Counseling Demonstration

Project No: 11-W-00118/02
Project Officer: Marguerite Schervish
Period: May 2000 to July 2008
Funding: $ 0.00
Principal Investigator: William Ditto
Award: Waiver-Only Project
Awardee: New Jersey, Department of Human Services
222 South Warren St, PO Box 700
Trenton, NJ 08625-0700

Status: New Jersey received approval to eliminate the randomization component of the demonstration design. All demonstration enrollees, including those once randomized into the control group, now have the ability to self-direct the provision of their personal care services. CMS granted New Jersey a three-year extension of demonstration authority, until April 30, 2008. CMS granted New Jersey three temporary extensions of the demonstration authority, first until May 31, 2008, then to June 30, 2008 and finally to July 31, 2008, to allow the State more time to submit a section 1915(j) State Plan amendment that would continue the self-directed services under this new State plan option. Section 1915(j) was enacted by the Deficit Reduction Act of 2005 to permit States to offer the opportunity for self-directed personal assistance services under the State plan instesd of a section 1115 demonstration or a section 1915(c) waiver program. New Jersey's section 1915(j) State plan amendment was approved by CMS on July 23, 2008 and the State's 1115 authority for the self-directed program expired on July 31, 2008.

Description: The purpose of these demonstrations was to provide greater autonomy to consumers of long-term care services by empowering them to purchase the assistance they required to perform activities of daily living. Section 1115 waiver projects were the States of Arkansas, Florida, and New Jersey. Persons chosen to participate in this demonstration were assigned to either a treatment or a control group. Beneficiaries selected for the treatment group received cash allowances, which they used to select and purchase the personal assistance services (PAS) that met their needs. Fiscal intermediary and counseling services were available to those members of the treatment group who wished to utilize them. Individuals assigned to the control group received PAS services from traditional Medicaid providers, with the State making all vendor payments. Other partners in this collaborative effort included the Robert Wood Johnson Foundation, which funded the development of these projects; the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services, which funded the evaluation; the National Program Office at the University of Maryland's Center on Aging, which performed various coordinating functions; and the National Council on Aging, which served in an advisory capacity. An evaluation contract was awarded to Mathematica Policy Research, Inc. to assess differential outcomes with respect to cost, quality, and client satisfaction between traditional PAS services and alternative choice modalities. ■

New Mexico Family Planning Expansion

Project No: 11-W-00111/6
Project Officer: Lane Terwilliger
Period: May 1997 to December 2010
Funding: $ 0.00
Principal Investigator: Carol Ingram
Award: Waiver-Only Project
Awardee: New Mexico Human Services Department, Medical Assistance Division
228 East Palace Avenue, La Villa Revera Bldg., 1st Floor
Santa Fe, NM 87501

Status: As of 3/31/2008, 29,028 individuals received family planning services through the demonstration.

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

New Mexico Health Care Reform Demonstration

Project No: 11-W-0012416
Project Officer: Andrea Casart
Period: January 2005 to December 2007
Funding: $ 0.00
Award: Waiver-Only Project
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: The continuation period ended on December 31, 2007.

Description: On September 14, 1998, New Mexico submitted a proposal for the New Mexico Section 1115 Demonstration Project, a 5-year section 1115 demonstration. On January 11, 1999, the State was permitted to implement its title XXI Medicaid expansion to cover children in families through age 18 with income from 185 percent up to 235 percent of the Federal Poverty Level (FPL). New Mexico operates its Title XXI State Children's Health Insurance Program (SCHIP) Medicaid expansion through this demonstration. This demonstration permits New Mexico to have co-payment requirements and a 6-month waiting period for the demonstration population. The State requested a 3-year extension of project number 11-W-0012416 entitled "The New Mexico Section 1115 Demonstration Project." The renewal was approved on June 14, 2004. This extension is authorized under 1115(e) of the Social Security Act. ■

North Carolina Family Planning

Project No: 11-W-00182/4
Project Officer: Lane Terwilliger
Period: November 2004 to September 2010
Funding: $ 0.00
Principal Investigator: Tara Larson
Award: Waiver-Only Project
Awardee: Division of Medical Assistance, Department of Health and Human Services
1985 Umstead Drive, 2517 Mail Service Center
Raleigh , NC 27699-2517

Status: As of 6/30/2008, 32,080 individuals received family planning services through the demonstration.

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

Northern New England Vascular Surgery Quality Improvement Initiative

Project No: 18-C-91674/01-02
Project Officer: Lindsey Bramwell
Period: September 2001 to September 2008
Funding: $650,000.00
Principal Investigator: Jack Cronenwett
Award: Grant
Awardee: Dartmouth University
HB 7850, 500 East Borwell, Research Building Dartmouth, Hitchcock Medical Center
Hanover, NH 03756

Status: A cooperative clinical data registry was developed among the nine major hospitals in NNE that perform 80 percent of all vascular surgery in the region. Data including indications, comorbidities, operative details, and outcomes will be collected for carotid endarterectomy, abdominal aortic aneurysm repair, and lower extremity bypass surgery. The developed shared data registry prospectively collects data on vascular procedures. Data includes indications, comorbidities, selected procedural details, and short-term outcomes and analyzes patterns of care and outcomes of hospitals and surgeons. The variations in procedure rates and risk-adjusted outcomes will be added to account for the differences in case mix to improve outcomes and reduce geographic variation in procedure rates by using benchmarking and visits by clinical teams from each center for comparative process analysis and continuous quality improvement.

Description: The Vascular Study Group of Northern New England (VSG-NNE) is a voluntary, cooperative group of clinicians, hospital administrators, and research personnel organized to improve the care of patients with vascular disease. By collecting and exchanging information, the group strives to improve the quality, safety, effectiveness, and cost of caring for patients with vascular disease in Maine, New Hampshire, and Vermont. ■

Nursing Home Value-Based Purchasing Demonstration

Project No: HHSM-500-2005-00018I/01
Project Officer: Ronald Lambert
Period: September 2006 to September 2011
Funding: $2,605,000.00
Principal Investigator: Alan White
Award: Task Order (MRAD)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The demonstration has been approved by the Office of Management and Budget. We will conduct a 2-stage solicitation. First, we will select up to 4 States to host the demonstration. Next, we will solicit nursing homes in those States to participate. The open solicitation phase is ongoing. We anticipate that the demonstration will begin in the Summer of 2009.

Description: The Nursing Home Value-Based Purchasing (NHVBP) demonstration is the CMS "pay-for-performance" initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing homes. Under this demonstration, CMS will provide financial incentives to nursing homes that demonstrate high standards for providing quality care. The demonstration will be financed from reductions in Medicare expenditures, primarily from reductions in inappropriate hospitalizations due to improved quality. We will include all Medicare beneficiaries who reside in a participating nursing home (i.e., those in a Part A SNF stay as well as those who receive only Part B benefits), many of whom are dually eligible for Medicare and Medicaid. We estimate that up to 200 hospital-based and free-standing nursing homes in up to four States will participate. ■

Oklahoma Family Planning

Project No: 11-W-00177/6
Project Officer: Lane Terwilliger
Period: November 2004 to March 2010
Funding: $ 0.00
Principal Investigator: Mike Fogarty
Award: Waiver-Only Project
Awardee: Oklahoma, Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Status: As of 9/30/2008, 16,476 individuals received family planning services through the demonstration.

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

Oklahoma SoonerCare Demonstration

Project No: 11-W-00048/06
Project Officer: Mark Pahl
Period: October 1995 to December 2009
Funding: $ 0.00
Principal Investigator: Mike Fogarty
Award: Waiver-Only Project
Awardee: Oklahoma, Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

Status: The State of Oklahoma has two pending amendments to modify the SoonerCare demonstration. If approved, the amendments would create a pilot program to allow for the establishment of Health Access Networks (HANs) and expans coverage for children up to 217% FPL.

Description: The SoonerCare demonstration provides services to TANF related populations and the aged and disabled with some exceptions. In 2005, TEFRA children and working disabled and non-disabled low income workers were added as expansion populations. In January 2009, the demonstration was amended to change the partially capitated delivery system to a Primary Care Case Management Model; expand the size of employers who can participate in the Employer Sponsored Insurance (ESI) program; and add full-time college students through age 22 as an expansion population. Primary objectives of the demonstration are to improve access to preventive and primary services, more closely align rural and urban providers, and instill a greater degree of budget predictability into Oklahoma's Medicaid program. ■

Orange County Government Primary Care Access Network (PCAN)

Project No: 1C0CMS030273/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $306,549.00
Principal Investigator: Pete Clarke
Award: Grant
Awardee: Orange County Board of County Commissioners
2100 East Michigan Street
Orlando, FL 32806

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The objective of this project is to improve access to care for more than 90,000 uninsured patients in Orange County by implementing an electronic information exchange and network wide eligibility system. ■

Oregon 1115 Independent Choices

Project No: 11-W-00130/00
Project Officer: Marguerite Schervish
Period: December 2001 to January 2008
Funding: $ 0.00
Principal Investigator: Genevieve Sundet
Award: Demonstration
Awardee: Oregon Senior and Disabled Services
500 Summer Street, NE
Salem, OR 97310-1015

Status: On January 26, 2007, CMS approved a one-year extension of the program, from February 1, 2007 until January 31, 2008, at which time the State's section 1115 program will expire. However, with the enactment of the Deficit Reduction Act of 2005, section 6087 (codified as section 1915(j) of the Social Security Act) permits States to offer self-directed personal assistance services (PAS) as part of their Medicaid State plans obviating the need for further waiver submissions. CMS understands that Oregon will pursue a section 1915(j) application to amend its State plan to add self-directed PAS. The project has been completed.

Description: This is an 1115 demonstration that allows individuals who are eligible for long-term care services to self-direct personal care and related services and to manage their cash allocation for these services. The program is available in three regions of the State for up to 300 consumers. This demonstration is similar in concept to the former approved Cash and Counseling demonstrations (now Independence Plus programs) in New Jersey, Florida, and Arkansas. The main difference is that Oregon's demonstration did not employ a randomized or experimental design. In addition, compared to Cash and Counseling, this demonstration requires all participants to manage their cash allowance. Monthly service allocations are paid directly into participants' Independent Choices checking accounts. Participants are responsible for deducting appropriate taxes and calculating employer payroll taxes. Participants pay their providers directly from their service allotment. A payroll service is available for participants who would like assistance and is required to be used by participants who have not passed a competency test to perform their fiscal responsibilities. The demonstration is less than Statewide and operates in three service areas with up to 100 participants enrolled in each site (Clackamas County, Coos/Curry Counties and Jackson/Josephine Counties). The State indicates in its proposal that the selection of these three sites allows the State to evaluate the replicability of the model Statewide and to evaluate the program in both urban and rural settings. Oregon's 1115 Independent Choices demonstration program was approved on November 22, 2000. Oregon submitted an amendment to allow payment to a participant's family, including the spouse of the participant. CMS approved the amendment on May 7, 2001. Oregon implemented the program on December 1, 2001. Current enrollment is about 300. On July 7, 2006, Oregon submitted a request to amend the program so it could operate statewide, and to extend the program. ■

Oregon Family Planning

Project No: 11-W-00142/0
Project Officer: Lane Terwilliger
Period: October 1998 to October 2009
Funding: $ 0.00
Principal Investigator: Jim Edge
Award: Waiver-Only Project
Awardee: Deptartment of Health and Human Services-Office of Medical Assistance Programs
500 Summer Street, NE E49
Salem , OR 97301-1079

Status: As of 9/30/2008, 85,419 individuals received family planning services through this demonstration.

Description: The purpose of the demonstration is to provide family planning services to uninsured men and women of childbearing age who are not otherwise eligible for Medicaid, SCHIP, or Medicare, and who have family income at or below 185% FPL. ■

Oregon Health Plan 2

Project No: 11-W-00160/00
Project Officer: Steven Rubio
Period: October 2002 to October 2010
Funding: $ 0.00
Principal Investigator: Jim Edge
Award: Waiver-Only Project
Awardee: Oregon, Department of Human Services
500 Summer St, NE - E10
Salem, OR 97301-1076

Status: On October 31, 2007, the State received a 3 year extension for its OHP waiver, through October 31, 2010. As part of the extension, funding for higher income adults was changed from title XXI to title XIX. March 2008 the State began mailing enrollment applications to individuals on its OHP reservation list, which is comprised of 90,000 uninsured Oregonians.

Description: The Oregon Health Plan (OHP) combines an original Medicaid and SCHIP demonstration with a HIFA waiver, and includes 3 benefit packages: OHP Plus - mandatory populations including pregnant women and children up to 185% FPL; OHP Standard - expansion parents and childless adults/couples up to 185% FPL; and FHIAP - a premium assistance program offerred to OHP members with available ESI. Savings are used to extend health care coverage to non-Medicaid populations, including higher income parents and caretaker relatives, and childless adults. The benefit packages for all groups are based on a prioritized list of services, which is updated every two years by the Oregon Health Services Commission. Two variations of the prioritized list package are provided. Medicaid State plan populations receive OHP Plus, a richer set of services, while most expansion populations receive a reduced set of benefits in the OHP Standard program. FHIAP is the only benefit program available to eligibles with income above the FPL. ■

Partnership for Early Childhood Health and Services

Project No: 18-P-93128/1-01
Project Officer: Lekisha Daniel-Robinson
Period: July 2005 to December 2007
Funding: $248,000.00
Principal Investigator: Michael Hastings
Award: Grant
Awardee: University of Maine
5717 Corbett Hall
Orono, ME 04469-5717

Status: The project is now complete.

Description: The objective of the project is to work with public and private programs statewide to develop voluntary systems for sharing information and knowledge regarding the background, needs, and experiences of children with developmental disabilities and their families while maintaining confidentiality and ensuring privacy. The result of this partnership will be a shared, population-based Developmental Disabilities Information System. ■

Partnership Plan

Project No: 11-W-00114/02
Project Officer: Camille Dobson
Period: July 1997 to September 2009
Funding: $ 0.00
Principal Investigator: Deborah Bachrach
Award: Waiver-Only Project
Awardee: New York, Department of Health, (Albany)
Empire State Plaza, Room 1466, Corning Tower Building
Albany, NY 12237

Status: In accordance with section 1115(a) of the Social Security Act, the State has submitted a letter affirming its intention to seek a three-year renewal of the demonstration.

Description: The Partnership Plan Demonstration was approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations. In 2001, the Family Health Plus program was implemented as an amendment

to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility standards. In 2002, the demonstration was further amended to provide family planning services to women losing Medicaid eligibility and certain other adults of childbearing age (family planning expansion program). Authority to mandate managed care enrollment for beneficiaries receiving SSI or otherwise aged or disabled as well as low-income families in 14 upstate counties was transferred to the Federal-State Health Reform Partnership (F-SHRP) demonstration in October 2006. The demonstration is funded by savings generated from the managed care delivery system. ■

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

Project No: 500-01-0033/03
Project Officer: Lawrence Caton
Period: May 2005 to November 2010
Funding: $3,190,826.00
Principal Investigator: C. William Wrightson
John Wilkin
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The funding was increased and will cover payment for the contractor's performance of work through December 31, 2009. The balance will be incrementally funded as funds become available.

Description: This task order supports the Centers for Medicare and Medicaid Services (CMS) in implementing approximately six regional programs to provide care management services to high cost Medicare fee-for-service beneficiaries under the Care Management for High-Cost Medicare Beneficiaries Demonstration (CMHCB). The assumption is that 8,000 beneficiaries will be placed in an intervention group and 8,000 in a control group for each of the 6 programs, yielding 80,000 to 120,000 beneficiaries for ongoing analysis. ■

Payment Development, Implementation, and Monitoring for Disease Management Demonstrations

Project No: 500-00-0036/02
Project Officer: Juliana Tiongson
Period: September 2004 to September 2009
Funding: $1,383,158.00
Principal Investigator: C. William Wrightson
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

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

Description: The purpose of this task order is to provide support to the Centers for Medicare & Medicaid Services (CMS) in implementing and monitoring demonstrations projects that provide disease management services to Medicare beneficiaries. These demonstrations include the LifeMasters Disease Management Demonstration for dually-eligible Medicare beneficiaries, and several other disease management demonstrations that are in the planning stages. Under this task order, the major tasks are: 1. Providing general technical support to CMS in the analysis of rate proposals and assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects; 2. Educating of demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements; 3. Monitoring payments and Medicare expenditures to assure budget neutrality, including designing data collection processes for use in collecting and warehousing necessary data elements from sites and CMS administrative records for assessing performance; and 4. Performing financial analysis to assist in the financial settlement and reconciliation. ■

Payment, Data Management, Implementation, and Monitoring Support for the Medicare Care Management Performance Demonstration

Project No: 500-00-0036/03
Project Officer: Jody Blatt
Period: September 2004 to September 2009
Funding: $1,777,854.00
Principal Investigator: John Wilkin
Award: Task Order (RADSTO)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The demonstration is operational and started its first performance year July 1, 2007. Approximately 650 small to medium sized physician practices are participating.

Description: This 3-year demonstration was mandated under Section 649 of the MMA to promote the use of health information technology and improve the quality of care for beneficiaries. Doctors in small to medium sized practices who meet clinical performance measure standards will receive a bonus payment for managing the care of eligible Medicare beneficiaries. The demonstration is being implemented in California, Arkansas, Massachusetts, and Utah. The purpose of this particular contract is to support CMS in implementing the Medicare Care Management Performance (MCMP) demonstration project and providing technical and administrative support to CMS in management of data and payment incentives to participating physician practices. ■

Pennsylvania Family Planning

Project No: 11-W-00235/3
Project Officer: Lane Terwilliger
Period: May 2007 to June 2012
Funding: $ 0.00
Principal Investigator: Michael Nardone
Award: Waiver-Only Project
Awardee: Pennsylvania, Department of Public Welfare
P. O. Box 2675
Harrisburg, PA 17105-2675

Status: The Pennsylvania Family Planning Demonstration was approved for an five-year initial period on 5/11/2007, and was implemented on 1/1/2008. On 4/1/2008, the State received approval for an amendment to modify list of allowable procedure codes for family planning services. As of 9/30/2008, 40,207 individuals received family planning services through the demonstration.

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

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

Project No: 500-00-0033/08
Project Officer: Pamela Cheetham
Louisa Rink
Period: February 2005 to November 2009
Funding: $6,059,875.00
Principal Investigator: Sue Felt-Lisk
Award: Task Order (MRAD)
Awardee: Mathematica Policy Research, (Princeton)
600 Alexander Park, PO Box 2393
Princeton, NJ 08543-2393

Status: The last routine performance monitoring quarterly reports are scheduled to be delivered by January 30, 2009. Program operations for phase one of this pilot project concluded in August 2008. Contractor/CMS assessment of the degree to which performance targets were achieved by each Medicare Health Support Organizations will continue through most of 2009. A final independent evaluation incorporating the performance monitoring data is due to Congress no later than February 2013.

Description: The performance-monitoring task order provides the means to monitor Medicare Health Support operations and collect data needed to track clinical performance of participating disease managment organizations and utilization of health resources by the intervention and control groups during Phase I of this pilot project. The monitoring process is dependent upon collaboration among several contractors, CMS, and the

Medicare Support Organizations (MHSOs) to ensure the specification, collection, storage, and reporting of accurate clinical data for Medicare beneficiaries in the intervention and control groups - particularly intervention group beneficiaries who actively participated in MHS. This data tracks the efforts of the individual MHSO and provides information to the independent evaluator. Comparative data will help inform a decision by the Secretary on potential program expansion, as specified in Section 721 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. ■

Performance Reporting and Administrative Support of CMS's Medicaid Grant Initiatives

Project No: HHSM-500-2006-00100G
Project Officer: Cathy Cope
Period: August 2006 to August 2011
Funding: $4,136,754.00
Principal Investigator: Jessica Kahn
Award: GSA Order
Awardee: Ascellon Corporation
8201 Corporate DriveSuite 950
Landover, MD 20785

Status: A contract Modification and execution of an Optional Task was executed in the amount of $357,813. The Modification was to add the 28 new Real Choice Grants and increase the expected attendance at the MIG conference from 110 to 200. The Optional Task, Product Inventory for DMIE Grants, is now an official task. The Contractor is completing the contract tasks on time, effectively and efficiently. The contractor has had difficulty keeping staff and the turnover has caused delays in completeing tasks. The contractor has been put on notice of the requirement to fulfill their obligations under the contract. By late December of 2008, all positions were filled.

Description: The purpose of this Task Order is to provide support to the Centers for Medicare and Medicaid Services (CMS) project officers that programmatically manage grants in the CMS Disabled and Elderly Health Programs Group (DEHPG) and the grant specialists, who are the principal administrators of the grant, in the CMS Office of Acquisition and Grants Management (OAGM). The pertinent grans and demonstration are: o Medicaid Infrastructure Grants (MIG; o Demonstration to Maintain Independence & Employment (DMIE); and o Real Choice Systems Change Grants - Fiscal Years 2002-2006 ORCSC). ■

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

Project No: HHSM-500-2005-00029I/05
Project Officer: Shannon Flood
Period: February 2007 to December 2010
Funding: $3,774,699.00
Principal Investigator: Barbara Gage
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: This project is in Phase II of development. Relevant data collection instruments have been developed, tested, and are implemented in a on-line application. Data collection is active in all project sites. Collection of data will continue through the end of 2009.

Description: As a component of the Deficit Reduction Act of 2005 (S1932.Title V.Sec 5008), Congress authorized the Post-Acute Care Payment Reform Demonstration (PAC-PRD). PAC-PRD will examine acute care hospitals and four types of PAC providers: Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). Work on the PAC-PRD is divided into three contracts. This task order comprises the third, implementation and analysis of the demonstration. This task order is broken into two phases. Phase I includes tasks relating to the development of the demonstration including creating analysis plans, determining how cost and resource use (CRU) shall be collected, recruitment of facilities, and a limited roll out of the demonstration in one referral network. Phase II includes data collection using the newly developed instruments, analysis of the data and report writing. Analysis topics include payment reform recommendation, predicting resource utilization, predicting discharge placement, and predicting outcomes. The Mandate/Authority of this contract is the Deficit Reduction Act of 2005. ■

Post-Acute Care: Patient Assessment Instrument Development

Project No: HHSM-500-2005-00029I/04
Project Officer: Judith Tobin
Period: November 2006 to March 2011
Funding: $6,473,642.00
Principal Investigator: Barbara Gage
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

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

Description: This task order will design and complete the development of the assessment instrument required by the 2005 Deficit Reduction Act (DRA). In general, this will involve designing, developing and organizing questions and instructions that direct the collection of the patient assessment data relevant to assessing function, clinical status, quality of care, use of resources and related purposes. The instrument will initially be documented on a usable paper-based format for review, reference, and potential interim use, but shall be designed to be an internet-based instrument that is interoperable across provider settings. ■

Practice Expense Methodology

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

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

Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule. Until January 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. In 1989, Congress established a fee schedule for the payment of physicians' services. Under the formula set forth in the law, the payment amount for each service is the product of three factors: - A nationally uniform relative value. - A geographic adjustment factor for each physician fee schedule area. - A nationally uniform conversion factor that converts the relative value units (RVUs) into payment amounts for services. The RVUs for each service reflect the resources involved in furnishing the three components of a physician's service: - Physician work (i.e., a physician's own time and effort). - Practice expenses net of malpractice expenses. - Malpractice insurance expenses. The original practice expense RVUs were derived from 1991 historical allowed charges. A common criticism was that for many items these RVUs were not resource-based because they were not directly based on the physician's resource inputs. CMS was required to implement a system of resource-based practice expense relative value units (PERVUs) for all physicians' services by 1998. The Balanced Budget Act of 1997 (BBA) made a number of changes to the system for determining PERVUs, including delay of initial implementation until 1999 and provision for a 4-year transition. To obtain practice expense data at the procedure code level, CMS convened Clinical Practice Expert Panels (CPEPs). The CPEPs provided the direct inputs of physician services, i.e., the amount of clinical and administrative staff time associated with a specific procedure and medical equipment and medical supplies associated with a specific procedure. In June 1997, we published a proposed rule for implementing resource-based practice expense payments. The methodology incorporated elements of the CPEP process to develop the direct expense portion of the PERVU. The indirect expense portion of the PERVU was based on an allocation formula. In addition to delaying the implementation of resource-based practice expense payments until January 1, 1999, the BBA phased in the new payments over a 4-year

transition period. In developing new practice expense RVUs, we were required to: - Utilize, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be linked to specific procedures. - Use actual data on equipment utilization and other key assumptions. - Consult with organizations representing physicians regarding methodology and data to be used. - Develop a refinement process to be used during each of the 4 years of the transition period. In June 1998, we proposed a methodology for computing resource-based practice expense RVUs that uses the two significant sources of actual practice expense data we have available: CPEP data and the American Medical Association's (AMA) Socioeconomic Monitoring System (SMS) data. This methodology is based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physicians' services across specialties. It then allocates these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach. We used actual practice expense data by specialty to create six cost pools: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools: - We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category. - We determined the total number of physician hours, by specialty, spent treating Medicare patients. - We then calculated the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours. For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group. For group one, which includes clinical labor, medical supplies, and medical equipment, we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively. For group two, which includes administrative labor, office expenses, and all other expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs were used to allocate the cost pools. For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients. The BBA also requires the Secretary to develop a refinement process to be used during each of the 4 years of the period. In the 1998 notice, we finalized the proposed methodology but stated that the PERVUs would be interim throughout the transition period. Additionally, we envisioned a two-part refinement process: - The AMA has established a Practice Expense Review Committee to review detailed, Current Procedural Terminology code level input data. - CMS will request contractual support for assistance on methodology issues. This project provides that contractual support. ■

Premier Hospital Quality Incentive Demonstration

Project No: 500-00-0015/02
Project Officer: Linda Radey
Period: September 2004 to December 2008
Funding: $999,970.00
Principal Investigator: Stephan Kennedy, Ph.D.
Kevin Coleman
Cheryl Damberg
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: The project is in its fourth and final year. A final evaluation report is in preparation.

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

Premier Hospital Quality Incentive Demonstration (HQID)

Project No: 95-W-00103/04
Project Officer: Katharine Pirotte
Period: October 2003 to September 2009
Funding: $ 0.00
Principal Investigator: Diana Jackson
Award: Waiver-Only Project
Awardee: Premier Healthcare Informatics
2320 Cascade Pointe Boulevard, Suite 100
Charlotte, NC 28208

Status: The demonstration involves a CMS partnership with Premier, Inc. a nationwide organization of not-for-profit hospitals that operates a quality measurement system. The demonstration began on October 1, 2003 with 278 Premier hospitals. The Medicare payments of the incentive bonuses for year 1 was about $8.85 million, $8.69 million for year 2 and $7.0 million for year 3. The average composite quality score and the aggregate of all quality measures within each clinical area improved significantly since the inception of the program in all 5 clinical focus areas. These clinical areas are acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacement. An extension of the HQID was approved from fiscal year 2007 through fiscal year 2009. The most notable changes in the extended demonstration are in the payment methodology, which includes incentives for quality improvement as well as for achieving high quality. The objectives are to test new payment models, ways to measure quality, and methods to support designing CMS value-based purchasing models.

Description: The purpose of the demonstration is to determine the effectiveness of improving the quality of inpatient care for Medicare beneficiaries by awarding quality incentive payments to hospitals for high quality in several clinical areas, and by reporting extensive quality data on the CMS Web site. ■

Prescription Assistance Program

Project No: 1C0CMS030268/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $ 95,305.00
Principal Investigator: Maximo Martinez
Award: Grant
Awardee: Gadsden Community Health Council, Inc.
216 North Adams Street
Quincy, FL 32351

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The Prescription Assistance Program under the Gadsden Community Health Council, Inc. helps patients with a gross income of 200% of the Federal Poverty Level or lower to receive prescription medications at little or no out-of-pocket cost. ■

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

Project No: 500-00-0047/02
Project Officer: David Baugh
Period: September 2002 to March 2009
Funding: $1,172,286.00
Principal Investigator: Jim Verdier
Award: Task Order
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: The contractor has prepared a full set of data tables in the form of a statistical compendium, using MAX data for the 50 States and Washington, D.C. The tables provide detailed information on prescription drug utilization and spending for three major populations: all Medicaid, dual enrollees and Medicaid nursing facility residents. The contractor has also produced a Chartbook "Medicaid Pharmacy Benefit Use and Reimbursement." The Statistical Compendium and Chartbooks are available for 1999, 2001-2003 on the CMS Web site at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp The Statistical Compendium and Chartbook using 2004 MAX data has been produced and is under review in ORDI. These products will be posted on the CMS Web page listed above in the near future. This contract has also produce research papers. One paper has been published and others are in review. The publication reference is: Bagchi, A., Esposito, D., and Verdier, J.: Prescription Drug Use and Expenditures Among Dually Eligible Beneficiaries. Health Care Financing Review, Summer 2007, Vol. 28, No. 4, pages 43-56.

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

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

Project No: HHSM-500-2006-00008I/01
Project Officer: Chris Haffer
Period: August 2006 to August 2009
Funding: $1,096,074.00
Principal Investigator: Wendy Funk
Award: Task Order (XRAD)
Awardee: Kennell and Associates, Inc.
3130 Fairview Park DriveSuite 505
Falls Church,VA 22042

Status: The project is ongoing. A modification to the "Deliverables Schedule" was incorporated into the contract in late 2008.

Description: The task order will produce and disseminate program statistics derived from the Section 723 chronic condition data warehouse (CCS). These program statistics will be used to help improve the quality of care and reduce the cost of care for chronically ill Medicare beneficiaries as requried by Section 723 of the Medicare Modernization Act. The objectives are two-fold: 1) to evalue the robustness of the CCW for research purposes. The contractor shall address the strengths and weakensses of the CCW; and 2) to create program statistics based on the contractor's analyses of the CCW. The analyses from the first objective should create a "blue print" of what statistics the CCW is capable of supporting. These newly created statistics should address emerging themes in chronic disease, such as preventive management, quality outcomes, and disease management. ■

Program to Enhance Medicaid Access for Low Income HIV-Infected Individuals in the District of Columbia (DC HIV/AIDS 1115 Demonstration)

Project No: 11-W-00131/03
Project Officer: Camille Dobson
Period: January 2001 to January 2010
Funding: $ 0.00
Principal Investigator: Robert Maruca
Award: Waiver-Only Project
Awardee: District of Columbia, Department of Health
825 North Capitol Street, NE, Suite 5135
Washington, DC 20002

Status: The Demonstration has been implemented and is operational. Two hundred forty-four individuals were enrolled as of 7/31/2008.

Description: This demonstration expands Medicaid coverage to HIV-positive individuals. Participants receive most services through an unrestricted fee-for-service delivery system, but are limited in their choice of pharmacy provider. The demonstration is funded by savings generated from the District purchasing HIV/AIDS drugs from the Department of Defense, rather than through the regular Medicaid program. ■

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

Project No: 500-02-0006/04
Project Officer: Gerald Riley
Period: September 2004 to September 2009
Funding: $199,987.00
Principal Investigator: Celia H. Dahlman
Award: Task Order (ADP Support)
Awardee: CHD Research Associates
5515 Twin Knolls Road #322
Columbia, MD 21045

Status: The contractor is currently completing activities related to updating the SEER-Medicare linked database. The update will add SEER cancer cases diagnosed in 2003-2005, and will add Medicare claims through 2007. The updated linkage is expected to be completed by the end of 2008.

Description: This project provides programming support for research projects involving the Surveillance, Epidemiology, and End Results (SEER)-Medicare database. The SEER-Medicare database has been in existence since 1991 and is the collaborative effort of the National Cancer Institute (NCI), the SEER registries, and CMS to create a large population-based source of information for cancer-related epidemiologic and health services research. The linked database combines clinical data on incident cancer cases from SEER with Medicare claims and enrollment information. Investigators from

both CMS and NCI use SEER-Medicare for studies of patterns and costs of cancer care. The purpose of this contract is to provide programming support for such studies through the creation of analytic files and development of statistical programs. CMS and NCI are both providing funds for this effort. ■

Public Reporting of Part D

Project No: HHSM-500-2006-00006I/03
Project Officer: Chris Powers
Period: August 2006 to December 2008
Funding: $657,382.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: A revised Statement of Work entitled, "Evaluation of Part D Sponsors' Low-Income Subsidy Match Rate" along with a revised schedule of deliverables were incoporated by reference and made a part of the task order in September 2007. The period of performance was extended, funded in the amount of $134,457, and two option years were added.

Description: This task order will develop the method to collect the Low Income Subsidy (LIS) data from the plans, design a data collection instrument and process, communicate with plans regarding the submission of LIS data, access the CMS LIS data and then compare and analyze the files and report the LIS match rate back to CMS. The contractor shall work with the government task leader to ensure a complete understanding of the LIS files and the LIS related analysis and reports required by CMS. ■

Public Reporting of Provider Quality

Project No: HHSM-500-2006-00009I/01
Project Officer: David Miranda
Period: July 2006 to September 2010
Funding: $3,001,720.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The Contractors technical proposal entitled "Public Reporting of Provider Quality: Research and Testing," the Contractor's responses to CMS technical questions, and the Contractor's technical proposal entitled "Public Reporting of Cost & Volume: Website Audience Testing" were incorporated by reference and made a part of this task order.

Description: This task order requires the Contractor to plan and conduct qualitative testing with patients, other consumers and clinicians on new measures for the Hospital Compare, Home Health Compare, and potentially other "Compare" tools, such as Nursing Home Compare. The Contractor shall also conduct qualitative testing on measures for the Medicare Prescription Drug Plan Finder and to potentially add to the Medicare Physician Finder. ■

Quality Indicator Survey (QIS) Training And Analysis

Project No: 500-00-0052/01
Project Officer: Karen Schoeneman
Period: July 2005 to September 2009
Funding: $3,308,154.00
Principal Investigator: Andrew Kramer
Award: Task Order (RADSTO)
Awardee: University of Colorado, Health Sciences Center
13611 East Colfax Ave., Suite 100
Aurora, CO 80011

Status: The contract was modified to increase the level of effort, and revise the Statement of Work and Schedule of Deliverables. The period of performance was extended to September 2009. The total funding was increased by $825,000. The contractor has continued maintaining a help desk and is now involved in a set of analytic tasks to assist CMS in design of additional features of the nursing home survey process including a new federal monitoring data system (DAR)and onsite review process (FOQIS), revisit survey, extended survey; as well as providing DAR data reports, analysis and training to federal survey personnel, data threshold revamping, periodic data reporting, providing revisions to QIS forms and processes according to analyses performed regarding the operation of the QIS in participating States, and providing expert

assistance to a programming contractor that is inserting the QIS into CMS' data systems.

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

Rationalize Graduate Medical Education Funding

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

Status: The Council's goals are to ensure that Utah's clinical training programs are producing the number and types of health professionals needed in the State and to stabilize and ensure the continuation of residency positions and programs. A regional planning method that surveys the population's health professional needs is intended to result in a more equitable distribution of resources. The grant is now fully funded. The Council is seeking ways to sustain its efforts once the demonstration waiver ends June 30, 2010.

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

Refining Cost to Charge Ratios for Calculating APC and DRG Relative Payment Weights

Project No: HHSM-500-2005-00029I/08
Project Officer: Philip Cotterill
Period: August 2007 to August 2008
Funding: $285,963.00
Principal Investigator: Kathleen Dalton
Award: Task Order (MRAD)
Awardee: Research Triangle Institute, (NC)
PO Box 12194, 3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Status: The project has been completed.

Description: The project builds upon findings from work conducted under contract No. 500-00-0024-TO12, "A Study of Charge Compression in Calculating DRG Relative Weights." Both projects explored refinements in the calculation of cost-to-charge ratios that are used to estimate the costs that form the basis for relative resource weights. This project focused on estimation of the claims-level costs used to construct APC weights under the outpatient prospective payment system (OPPS), and replicated the inpatient analyses conducted earlier using the new Medicare-severity DRGs (MS-DRGs) introduced in FY 2008. The findings provide the basis for three types of recommendations: better use of existing cost report and claims data; application of statistically adjusted cost report data; and changes to the cost report forms or national claims databases. An interim report was posted on RTI's website on April 30, 2008, to coincide with the publication of the FY 2009 proposed rule for the Inpatient Hospital Prospective Payment System (IPPS). The final report was posted by RTI on July 3, 2008, to coincide with the publication of the FY 2009 proposed rule for the Outpatient Hospital Prospective Payment System (OPPS). ■

Research Data Assistance Center (ResDAC)

Project No: HHSM-500-2005-00027I/03
Project Officer: Linh Kennell
Period: September 2008 to September 2013
Funding: $999,972.00
Principal Investigator: Kevin Mckoskey
Award: Task Order (MRAD)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: The project is underway.

Description: The purpose of the ResDAC contractor is to assist the Centers for Medicare and Medicaid Services (CMS) to increase the number of researchers skilled in accessing and using CMS data for studies which may improve the Medicare and Medicaid programs and add value to current CMS activities. This contract will continue the activities of the original ResDAC which was originally awarded in 1996, the incumbent, the University of Minnesota was the successful awardee under this current contract. ■

Research Data Assistance Center (ResDAC)

Project No: 500-01-0043
Project Officer: Spike Duzor
Period: September 2001 to December 2008
Funding: $939,000.00
Principal Investigator: Marshall McBean
Award: Contract
Awardee: University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Mail Code Number 99
420 Delaware Street SE, D 355 Mayo Building
Minneapolis, MN 55455

Status: The contract has been extended to December 2008. Within the last year, the total funding of this contract has increased to $939,000.

Description: This project assists researchers who are not familiar with the data available at CMS. ResDAC staff members describe CMS data and helps researchers with the process of gaining an approved Data Use Agreement. This project will provide: technical on-site analytic support and training in accessing administrative and claims databases, linking databases, and creating analytic databases; training modules for data access and use by external organizations/researchers; and consultative and data support functions for governmental and non-governmental research. This is a follow-on award from a competitive procurement, to the incumbent contractor. It will be incrementally funded over its life. Thus, this award continues the work of the first ResDAC contract, 500-96-0023. ■

Research Data Distribution Center

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

Status: The period of performance was extended through December 31, 2008. Special Invoice Requirements Pursuant to the requirements of Task 5, "Track and Report Information on Customer Orders" of the Statement of Work, the Contractor will submit monthly invoices to include: 1) a total accounting of all reimbursable charges for both private researchers and Federal agencies 2) a separate total breakout of all reimbursable charges for private researchers 3) a separate breakout of all reimbursable charges for each of the Federal agencies provided data, and 4)a total cumulative reimbursable charges by private researchers and each Federal agency.

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

Research on State Management Practices for the Rebalancing of State Long-Term Care Systems

Project No: 500-00-0053/03
Project Officer: Kathryn King
Period: September 2004 to August 2008
Funding: $2,111,440.00
Principal Investigator: Linda Clark-Helms
Rosalie Kane
Robert Kane
Award: Task Order (RADSTO)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: The Final Report and a related products can be found at: http://www.hpm.umn.edu/ltcresourcecenter/research/rebalancing/Rebalancing_state_ltc_systems.htm

Description: In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study of up to eight States to explore various management techniques and programmatic features that States put in place to rebalance their Medicaid long-term services supports (LTSS) systems and their investments in LTSS towards community care. CMS contracted for a longitudinal study with qualitative and quantiative components that utilized a wide variety of methods. In addition to a Final Report, the study produced 3 sets of case studies at different time periods of the 8 States; 6 topic papers related to the theme of rebalancing, ising information from all or some of the 8 States; and 6 quantiative chartbooks that examine expenditure patterns for consumers of LTSS in the community and in institutions. ■

Research on System Change for Community Living

Project No: 500-00-0044/02
Project Officer: Cathy Cope
Period: September 2001 to September 2008
Funding: $3,979,996.00
Principal Investigator: Janet O'Keefe
Award: Task Order (RADSTO)
Awardee: Research Triangle Institute, (DC)
1615 M Street, NW, Suite 740
Washington, DC 20036-3209

Status: This project has been extended for an additional year with a no-cost extension in order for contractor to complete final reports of grants. Most of the RCSC Grants have been extended for an additonal year and this project includes the final analysis and reports for all the grants that began between 2001 and 2004. The first Final report for Grants that ended in 2004 and 2005 was released. The contract was recently modified to revise the schedule of deliverables to add the following topic paper: Topic paper #08 - Accomplishments and challenges of the Grantees focused on quality assurance and quality improvement initiatives. A draft of the paper would be submitted by January 2008, and the final topic paper is due by Febuary 28, 2008. The project is now completed.

Description: The Center for Medicare and Medicaid Services (CMS) has awarded a number of Systems Change Grants for Community Living. The goal of this related project is to conduct both formative and summative evaluation activities. The project will capture relevant data about: • The target populations selected by the grantees for systemic change activities; • The specific long-term care needs of the populations to be addressed in systems change activities; • The similarities and differences between methods selected by grantees to address the needs identified in their State; • The challenges and barriers faced by grantees in addressing the long-term care needs of their selected populations; • The changes made in the provision of long-term care in the grantee States as a result of the activities of the grantees; • The factors influencing environments to create successful systems change. The project will also establish the initial framework and foundation for future summative evaluation activities, including: • Outcome evaluations to measure whether the Systems Change Grants have caused demonstrable effects; • Impact evaluation – to assess the net effects both intended and unintended of the Systems Change Grants; • Value evaluation – to examine the cost effectiveness of systems changes, the individual value to the consumer in the promotion of dignity, independence, individual responsibility and choice, and self-direction, as well as the value to the community. Specifically, the project will: (1) Collect, analyze and evaluate data from the systems change activities of Systems Change Grantees regarding: (a) the extent of effectiveness and impact of consumer involvement in programmatic design, implementation and evaluation; (b) the types of direct services provided using grant funds, including the amount, duration and scope of services provided; (c) the types of changes made in State Medicaid Programs to achieve enduring systems change; (d) the changes in delivery of long-term services and supports and payment systems under State Medicaid Programs and other funding streams; (2) Evaluate innovative systems and methods for delivery of community-based long-term care services and supports;

(3) Perform research to assess the need for structural reforms of State Medicaid Programs, and other Federal programs supporting long-term care; (4) Develop tools for measuring changes in access, availability, quality, and value of community-based long-term care; (5) Develop improved information resources to assist consumers and their representatives in choosing long-term care providers and supports; (6) Evaluate new payment and delivery models to improve access, availability, quality, and value of community-based long-term services and supports for children and adults of any age with a disability or long-term illness. (7) Prepare reports and presentations for CMS and other audiences based upon specified analysis. ■

Rhode Island RIte Care

Project No: 11-W-00004/01
Project Officer: Camille Dobson
Period: November 1993 to September 2011
Funding: $ 0.00
Principal Investigator: Marge Ware
Award: Waiver-Only Project
Awardee: Rhode Island, Department of Human Services, Division of Medical Services
600 New London Avenue
Cranston, RI 02921

Status: The title XXI demonstration ended 9/30/2008. The groups covered under the title XXI demonstration are now covered through the state plan or through the title XIX demonstration. The RIteCare Demonstration will come to an end and be replaced by the Global Consumer Choice Demonstration (11-W-00242/1) once the latter is implemented. The target date for implementation of the Global Consumer Choice Demonstration is May 1, 2009.

Description: The Rhode Island RIte Care demonstration is a statewide program that delivers primary and preventive health care services for all Family Independence Program families (formerly known as AFDC families) and certain low-income women and children through a fully capitated managed care delivery system. The Demonstration also includes RIte Share, a premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI). Under RIte Share, the State pays all or part of an eligible family's monthly premium, based on income and family size, for an employer's Department of Human Services (DHS)-approved ESI. RIte Share provides coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments. Finally, the State provides replacement windows in the homes of lead-poisoned children enrolled in the demonstration. ■

Rural Hospice Demonstration: Quality Assurance Metrics Implementation Support

Project No: HHSM-500-2005-00034C
Project Officer: Cindy Massuda
Period: September 2005 to September 2010
Funding: $422,491.00
Principal Investigator: Susan Lorentz
Award: Contract
Awardee: HCD International, Inc.
4390 Parliament Place
Lanham, MD 20706-1808

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

Description: The purposes of the Rural Hospice Demonstration contract for quality assurance support for two demonstration hospices are: 1) Quality Measure Identification and Template Development to achieve standard formats and consistent data collection; 2)Analysis to verify and validate data submitted and to evaluate the usefulness and appropriateness of domains, measure, elements, templates, education strategies, and performance improvement projects; 3) Provider Education to assist the demonstration sites with on-going quality metrics education through the use of CD-ROMs, manuals, and other sources to develop the concept of quality through the hospice program; and 4) Quality Improvement Program Implementation Support to assist demonstration sites in evaluating effectiveness of performance improvement projects and revision, as necessary. ■

Safety Net Benefit Program

Project No: 11-W-00214/06
Project Officer: Mark Pahl
Period: March 2006 to September 2011
Funding: $ 0.00
Principal Investigator: Roy Jeffus
Award: Waiver-Only Project

Awardee: Arkansas, Department of Health and Human Services Division of Medical Services
PO Box 1437, Slot S401, 700 Main Street
Little Rock, AR 72203-1437

Status: The Safety Net Benefit Program was implemented October 1, 2006 and will run through September 30, 2011.

Description: Arkansas' HIFA initiative, the Arkansas Safety Net Benefit Program, provides a "safety net" benefit package through a public/private partnership for uninsured individuals with incomes at or below 200 percent FPL. ConnectCare, the State's PCCM program formerly operated under 1915(b) authority, also has been subsumed into this demonstration. ConnectCare is mandatory for TANF, TANF-related, SSI and SSI-related populations. Services provided under the safety net benefit package are delivered through the NovaSys Health provider network. The ConnectCare population continues to receive services through the State's ConnectCare PCCM Program network of providers. The objective of the demonstration is to target and assist uninsured low-wage employees of small businesses in Arkansas. ■

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

Project No: HHSM-500-2005-00028I/02
Project Officer: Elizabeth Goldstein
Period: September 2006 to September 2009
Funding: $7,094,773.00
Principal Investigator: Marc Eliott
Award: Task Order (MRAD)
Awardee: RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138

Status: The funding was increased and the contract was modified to exercise Option Year 2.

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

Second Generation Social Health Maintenance Organization Demonstration: Health Plan of Nevada

Project No: 95-W-90503/09
Project Officer: Dennis Nugent
Period: November 1996 to December 2007
Funding: $ 0.00
Principal Investigator: Ronnie Grower
Award: Waiver-Only Project
Awardee: Health Plan of Nevada, Inc.
P.O. Box 15645
Las Vegas, NV 89114-5645

Status: The project's final Report to Congress was released by the Secretary of Health and Human Services in February 2003. The purpose of this report was to present an analysis of the S/HMO II model. The S/HMO demonstration ended on December 31, 2007.

Description: The purpose of the second-generation social health maintenance organization (S/HMO-II) demonstration was to refine the targeting and financing methodologies and the benefit design of the original S/HMO model. The S/HMO integrated health and social services under the direct financial management of the provider of services. All acute and long-term-care services were provided by or through the S/HMO at a fixed capitation payment. The S/HMO-II provided an opportunity to test a model of care focusing on geriatrics. The Health Plan of Nevada (HPN) was the only one of the six organizations selected to participate in the project to implement the demonstration. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 continued the demonstration until 18 months after the Secretary submitted the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 extended the demonstration until 30 months after the S/HMO Transition Report to Congress was submitted. This report addressed transitioning S/HMOs and similar plans to the Medicare+Choice program. The report was sent to Congress in February 2001. Under its discretionary authority, CMS extended the demonstration two more times through December 31, 2007. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent

blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. In 2005 through 2007, the demonstration's payment methodology was based on a 70/30, 50/50, and 25/75 percent blend, respectively. A frailty adjustment continued through 2007. ■

Second Phase of the HIFA Evaluation Study

Project No: HHSM-500-2005-00027I/02
Project Officer: Paul Youket
Period: July 2006 to February 2009
Funding: $578,508.00
Principal Investigator: Bryan Dowd
Award: Task Order (MRAD)
Awardee: University of Minnesota
450 Gateway Building, 200 Oak Street SE
Minneapolis, MN 55455

Status: The contract was modified to authorize the exercise of Optional Task 2.3.2 at the estimated cost of $177,426. The contract is now fully funded.

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

Seven Twenty Three (723) Chronically Ill Disease Research Data Warehouse - Phase II

Project No: HHSM-500-2005-00182G
Project Officer: Spike Duzor
Period: September 2005 to September 2008
Funding: $7,981,604.00
Award: GSA Order
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway
West Des Moines, IA 50266

Status: The contract has been modified to authorize the purchase of two server bundles and applicable Oracle licensing. It was modified to exercise Options I and II and was extended to September 2008. This additional equipment will house Part D drug event data. The contractor developed a system to load and link Part D drug data to Medicare Part A and B claims. All tasks were sucessfully completed and the contract ended in September 2008. Another CMS contractor, Buccaneer Computer System and Services Inc. will maintain and distribute the Chronic Condition WArehouse data in the future.

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

SHIP Measurement and Reporting System

Project No: HHSM-500-2005-00019I/2
Project Officer: Patricia Gongloff
Period: September 2008 to September 2009
Funding: $679,996.00
Principal Investigator: Ben Smith
Award: Task Order (XRAD)
Awardee: American Institute for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007-3835

Status: The project is underway.

Description: As demands, expectations and funding for the State Health Insurance Assistance Program (SHIP) increase under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, CMS requires an improved performance measurement system to manage the program effectively. Increased accewss to information on Medicare covered services including preventive benefits; personalized counseling services; partnership development and assistance in accessing benefits, including enrollment assistance provided to beneficiaries in the Medicare Prescription Drug Coverage Program are goals for the SHIP network. The purpose of this task order is to further improve and provide maintenance support to the current SHIP National Performance Reporting system and performance measurement process and implement performance targets

established by CMS. Therefore, CMS will be able to determine whether SHIP programs meet the goals set forth by CMS and in the enabling legislation, Section 4360 of OBRA 1990 (Public Law 101-508), and the outreach and education requirements of the Balanced Budget Act of 1997 (BBA), and MMA. The contractor will generate SHIP performance reports and other ad hoc reports based on data gathered for the most recent reporting periods, providing technical assistance to SHIP programs o their data reporting systems, analyze data and the performance of SHIPs relative to the SHIP performance targets, and assess the need for revised or different performance targets and data requried to support those targets. ■

SHIP Performance Measurement and Reprot System

Project No: HHSM-500-2005-00019I/01
Project Officer: Patricia Gongloff
Period: September 2007 to September 2008
Funding: $903,362.00
Principal Investigator: Ben Smith
Award: Task Order (MRAD)
Awardee: American Institute for Research
1000 Thomas Jefferson St., NW
Washington, DC 20007-3835

Status: The contract has ended.

Description: As demands, expectations and funding for the State Health Insurance Assistance Program (SHIP) increase under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA0, CMS requires an improved performance measurement system to manage the program effectively. Increased accewss to information on Medicare covered services including preventive benefits; personalized counseling services; partnership development and assistance in accessing benefits, including enrollment assistance provided to beneficiaries in the Medicare Prescription Drug Coverage Program are goals for the SHIP network. The purpose of this task order is to further improve and provide maintenance support to the current SHIP National Performance Reporting system and performance measurement process and implement performance targets established by CMS. Therefore, CMS will be able to determine whether SHIP programs meet the goals set forth by CMS and in the enabling legislation, Section 4360 of OBRA 1990 (Public Law 101-508), and the outreach and education requirements of the Balanced Budget Act of 1997 (BBA), and MMA. The contractor will generate SHIP performance reports and other ad hoc reports based on data gathered for the most recent reporting periods, providing technical assistance to SHIP programs o their data reporting systems, analyze data and the performance of SHIPs relative to the SHIP performance targets, and assess the need for revised or different performance targets and data requried to support those targets. ■

Sixty Plus Senior Care Transition

Project No: 1C0CMS030274/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $191,593.00
Principal Investigator: Nancy Morrison
Award: Grant
Awardee: Piedmont Hospital
1968 Peachtree Road
Atlanta, GA 30309

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The program goal is to establish hospital and community partner interventions/processes to ensure safe and effective transitions for older adult patients and their caregivers, as they travel across the healthcare continuum and to home. ■

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

Project No: 95-P-09101/02
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $ 0.00
Principal Investigator: Eli Feldman
Award: Waiver-Only Project
Awardee: Elderplan, Inc.
745 64th Street
Brooklyn, NY 11220

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The

demonstration's payment methodology was based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend; but, in 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment continued through 2007. The extension served as a transition plan so that by the end of 2007, when the demonstration ended, the organization would be able to convert to a Medicare Advantage plan. The project is now complete.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute-care service component. Elderplan implemented its service delivery network in March 1985. Elderplan uses Medicare waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration, and 10 percent based on the new risk-adjustment system with the additional frailty adjustment. Elderplan enrollment at the end of 2005 was over 15,000 members. ■

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

Project No: 95-P-09103/00
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $ 0.00
Principal Investigator: Lucy Nonnenkamp
Award: Waiver-Only Project
Awardee: Kaiser Permanente Center for Health Research
2701 NW Vaughn Street, Suite 160
Portland, OR 97210

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The demonstration's payment methodology was based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend; but, in 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment continued through 2007. The extension served as a transition plan so that by the end of 2007, when the demonstration ended, the organization would be able to convert to a Medicare Advantage plan. The project is now complete.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services were provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites originally were selected to participate - two were health maintenance organizations (HMOs) that have added long-term care services to their existing service packages, and two were long-term care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the HMO sites that developed and added a long-term care component to its service package. Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II uses Medicare waivers only. The Balanced Budget Act (1997) extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act (1999) extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO

Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice Program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk-adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. Senior Advantage II enrollment at the end of 2005 was over 5000 members. ■

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

Project No: 95-P-09104/09
Project Officer: Dennis Nugent
Period: August 1984 to December 2007
Funding: $ 0.00
Principal Investigator: Timothy C. Schwab
Award: Waiver-Only Project
Awardee: SCAN Health Plan
3800 Kilroy Airport Way, Suite 100
P.O. Box 22616
Long Beach, CA 90801-5616

Status: Under a transition plan, CMS extended the demonstration through December 31, 2007. The demonstration's payment methodology was based on the CMS-HCC risk-adjustment model using a 70/30 percent payment transition blend; but, in 2006 and 2007, the payment methodology will change to a 50/50 and a 25/75 percent blend, respectively. A frailty adjustment continued through 2007. The extension served as a transition plan so that by the end of 2007, when the demonstration ended, the organization would be able to convert to a Medicare Advantage plan. The project is now complete.

Description: This project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites originally were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component. SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (2000) further extended the demonstration until 30 months after the S/HMO Transition Report to Congress is submitted. This report addresses transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. The report was sent to Congress in February 2001 making the end date July 2003. CMS, using discretionary authority, extended the demonstration through December 31, 2004. Payment for the S/HMO demonstration in 2004 was determined by the CMS-Hierarchical Condition Category risk adjustment model with a frailty adjuster employing a 90/10 percent blend. The blend was 90 percent of the payment based on the methodology in prior use during the demonstration and 10 percent based on the new risk adjustment system with the additional frailty adjustment. SCAN Health Plan enrollment at the end of 2005 was over 76,000 members. ■

Solicitation Management and Provisions of Remote Panel Reviews

Project No: HHSM-500-2006-00054G
Project Officer: Sona Stepp
Period: May 2006 to April 2009
Funding: $734,542.00
Principal Investigator: Lynn Leeks
Award: GSA Order
Awardee: LCG, Inc.
1515 Wilson Blvd
Rosslyn, VA 22209

Status: A modification was executed on this contract to extend the project period. Additional grant solicitations were appropriated by Congressthat resulted in increasing the amount of the contract. The Contactor is completing the contract tasks on time, effectively and efficiently. The Contract is still in effect, but there are no funds remaining. We plan to increase the funding for the FY

2009/FY 2010 MIG and RCSC solicitations through an additional Modification.

Description: The purpose of this task order is to provide complete grant application management and provision of remote grant panel reviews supporting the new Freedom Initiative and the Deficit Reduction Act of 2005 (DRA) Grant Programs. The contractor will manage the panel reviewer teleconferences for each panel. ■

South Carolina Family Planning

Project No: 11-W-00057/4
Project Officer: Lane Terwilliger
Period: December 1993 to December 2010
Funding: $ 0.00
Principal Investigator: Emma Forkner
Award: Waiver-Only Project
Awardee: South Carolina, Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Status: As of 9/30/2008, 47,025 individuals received family planning services through this demonstration.

Description: This demonstration provides coverage for family planning services for uninsured women with countable income at or below 185% FPL, who are not otherwise eligible for Medicaid or SCHIP. ■

Study of Paid Feeding Assistant Programs

Project No: 500-00-0049/02
Project Officer: Susan Joslin
Period: September 2004 to September 2008
Funding: $597,374.00
Principal Investigator: Terry Moore
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Phase II was completed in September 2008. The final report will be posted once it has been converted into a 508 compliance format. Phase I was completed in September 2007. The final report for the Phase I project is available at:http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=dual,%20keyword&filterValue=paid%20feeding%20assistant&filterByDID=0&sortByDID=4&sortOrder=ascending&itemID=CMS1203286&intNumPerPage=10

Description: The purpose of this Phase II Study of Paid Feeding Assistants is to design, implement and evaluate an optimal feeding assistant program, one that is not only consistent with federal requirements for paid feeding assistant (PFA) training but that provides more hands-on guidance for both supervisory and feeding assistant staff about how to enhance the quality of both the dining experience and the nutritional intake of the nursing home resident. ■

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

Project No: 1C0CMS030277/01
Project Officer: Maria Sotirelis
Period: July 2008 to December 2009
Funding: $ 95,305.00
Principal Investigator: Timothy Ives
Award: Grant
Awardee: University of North Carolina at Chapel Hill
School of Pharmacy, Box 7360
Chapel Hill, NC 27599

Status: The project is continuing with its implementation efforts. These efforts include: 1) developing and executing the required partnerships, and 2) obtaining data from each participating practices.

Description: The goal of this study is to improve the effectiveness and safety of drug therapies required by Medicare beneficiaries through the provision of a structured, documented chronic disease case management service delivered to Medicare-eligible beneficiaries who are referred by their collaborating physicians, in communities with a high population of Medicare recipients. The objective of this study is to examine the role of the clinical pharmacist practitioner (CPP) in managing drug treatment to reduce costs and improve the quality of care for Medicare beneficiaries. The methodology will be a retrospective analysis of Medicare claims data for beneficiaries who did receive

CPP services. The claims data for this population could be compared to beneficiaries who did not receive CPP services. The following parameters will be assessed: Number of office visits, number of hospitalizations/ emergency room visits, charges per visit. ■

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

Project No: HHSM-500-2006-00006I/08
Project Officer: Steve Blackwell
Period: August 2007 to June 2010
Funding: $621,156.00
Principal Investigator: Grecia Marrufo
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: A contract was awarded to Acumen in September 2007 to conduct this research. The contractor is presently performing data analysis for the study.

Description: This Task Order further studies the issues involved with the relationship between Part B and Part D drug coverage as indicated in the Secretary's 2005 Report to Congress on Transitioning Medicare Part B Covered Drugs to Part D. That report, which was mandated under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), suggested that there were a limited number of categories of drugs where it might be beneficial to consolidate coverage under one program. However, the Secretary recommended, given the complexity of the issues, that further analyses would be necessary once Medicare had at least two years of experience with the new prescription drug program. This study aims to better understand the financial and programmatic impacts of consolidating certain categories of similar drugs under one program. ■

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

Project No: HHSM-500-2006-00005I/06
Project Officer: Debbie Vanhoven
Period: January 2008 to February 2017
Funding: $425,000.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The recruitment period for practices in the four Phase I sites ended November 26, 2008. The contractor, Actuarial Research Corporation (ARC), is responsible for reviewing and tracking applications received from primary care practices in those sites and will identify those practices eligible for randomization into Treatment and Control groups. In addition, the contractor will provide a critical ongoing consultative role in the implementation and operation of the EHR Demonnstration including, but not limited to: aggregation of claims data, beneficiary assignment and calculation of payment incentives under the demonstration.

Description: This task order will support the Centers for Medicare & Medicaid Services (CMS) in implementing and providing technical and administrative support to CMS in the operation fo two pay for performance demonstrations: the Medicare Care Management Performance Demonstration (MCMP) and the electronic Health Recores (EHR) Demonstration. The implementatin contractor shall be responsible for diverse tasks required for implementing and operating both demonstrations. ■

Sustaining Culture Change In Long Term Care

Project No: 1C0CMS030269/01
Project Officer: Michael Henesch
Period: July 2008 to December 2009
Funding: $ 95,305.00
Principal Investigator: Cheryl Cooper
Award: Demonstration
Awardee: Jefferson Area Board for Aging
674 Hillsdale Ave., Suite 9
Charlottesville, VA 22901

Status: The first status report is due January, 2009.

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

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

Project No: 500-00-0049/03
Project Officer: Cathy Cope
Period: September 2005 to September 2011
Funding: $4,197,421.00
Principal Investigator: Yvonne Abel
Award: Task Order (RADSTO)
Awardee: Abt Associates, Inc.
55 Wheeler St.
Cambridge, MA 02138

Status: Summaries of susequent year grants have been completed and are on the CMS website. The Strategic Plan Template and initial onsite visits for the Systems Transformation (ST) Grantees have been completed. All Tasks and activities on are time. Finalization of Strategic Plan web format and review and approval of ST Grantees Strategic Plans are completed. The web-based RCSC Grant Program management reports are in development. The contract was recently modified to: (1) increase the level of effort for Task 7,(2) modify Task 4 and (3) revise the Statement of Work and the Schedule of Deliverables.

Description: The purpose of this task order is to: examine the systems and impacts of the Fiscal Year 2005 Real Choice Systems Change (RCSC) Grants; provide limited technical assistance (TA) to Centers for Medicare and Medicaid Services (CMS) regarding strategic planning and grants management; and provide limited TA to FY05 RCSC Grantees regarding strategic planning, evaluation strategies and outcome measurement. The information from this work will be used to inform interested partners within the Department of Health and Human Services, congressional sponsors, all Systems Change Grantees, and Federal and State decision-makers. This task order will run for the duration of the FY05 RCSC Grants in order to capture the activities and outcomes of the specific grants being evaluated under this task order. ■

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

Project No: 1IOCMS030310/01
Project Officer: Richard Bragg
Period: September 2008 to September 2010
Funding: $225,000.00
Principal Investigator: Elizabeth Bertera
Award: Grant
Awardee: Howard University OSP-Research Administration
576 W Street NW
Washington, DC 20059

Status: The is a new grant under the HBCU Health Services Research Grant.

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

Technical Assistance Resource Center for Direct Service Workforce Development

Project No: 500-00-0051/06
Project Officer: Kathryn King
Period: September 2005 to September 2008
Funding: $1,759,532.00
Principal Investigator: Lisa Maria Alecxih
Award: Task Order (RADSTO)
Awardee: Lewin Group
3130 Fairview Park Drive, Suite 800
Falls Church, VA 22042

Status: Work on this contract was completed on September 25, 2008. See the RC Web site for materials produced from this contract: www.dswresourecenter.org

Description: The purpose of this task order is to provide funding to create CMS National Direct Service Workforce Resource Center (RC)to respond to the large and growing shortage of workers who provided direct care and personal assistance to individuals who need long term supports and services. The RC provided general and intensive technical assistance (TA) to State and local governments, not-for-profit organizations and the Centers for Medicare and Medicaid Services (CMS) for the purpose of recruitment, training, and retention of direct service workers (DSWs) for persons with disabilities and elderly individuals with long term illnesses. The DSW RC also offers: a comprehensive online searchable databace of resources, research, best practices, and policy briefs related to improving recruitment & retention of DSWs; a national toll free number to access advice/ information from national experts; educational webinars; and quarterly newsletters. ■

Technical Oversight and Support

Project No: HHSM-500-2006-00005I/07
Project Officer: Lawrence Caton
Period: September 2008 to September 2009
Funding: $295,851.00
Principal Investigator: John Wilkin
Award: Task Order (XRAD)
Awardee: Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, VA 22003

Status: The project is underway.

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

TennCare II

Project No: 11-W-00151/04
Project Officer: Kelly Heilman
Period: May 2002 to June 2010
Funding: $ 0.00
Principal Investigator: Darin Gordon
Award: Waiver-Only Project
Awardee: Tennessee, Department of Finance and Administration, TennCare Bureau
301 Great Circle Road
Nashville, TN 37243

Status: The State has nearly completed disenrollment of adult Demonstration eligibles, and transition of persons enrolled in the closed Medically Needy group into the new Medically Needy Demonstration group is also nearly complete. An amendment was approved on 7/20/2008 to allow limitations on home health and private duty nursing benefits in TennCare. A requested amendment to provide a capitated long-term care benefit in TennCare is under consideration by CMS.

Description: TennCare II, implemented July 1, 2002, replaced the original TennCare Demonstration (11-W-0002/04), which ended on July 30, 2002. Like its predecessor, the TennCare II Demonstration uses savings from mandatory Medicaid managed care and reallocation of Disproportionate Share Hospital funds to extend Medicaid eligibility to selected low-income uninsured populations. All Medicaid State Plan eligibles are enrolled in managed care under TennCare II, except those whose only Medicaid benefits consist of Medicare premium payments. State Plan populations receive the TennCare Medicaid benefit package, while expansion population receive TennCare Standard, with some State Plan benefits omitted. Since 2005, significant changes have been made to the list of covered populations. Coverage has been discontinued for demonstration eligible uninsured adults, and the State plan non-pregnant medically needy adults group was closed to new enrollment. In November 2006, an amendment was approved to cover non-pregnant medically needy adults as a Demonstration Population, with enrollment capped at 105,000. ■

Texas Family Planning

Project No: 11-W-00233/6
Project Officer: Lane Terwilliger
Period: December 2006 to December 2011
Funding: $ 0.00
Principal Investigator: Chris Taylor
Award: Waiver-Only Project
Awardee: Texas Health and Human Services Commission
1100 West 49th Street, Mail Code H100, P.O. Box 85200
Austin , TX 78708

Status: As of 9/30/2008, 86,713 individuals received family planning services through this demonstration.

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

Thurston County Project Access

Project No: 1C0CMS030276/01
Project Officer: Carl Taylor
Period: July 2008 to December 2009
Funding: $191,593.00
Principal Investigator: Susan Peterson
Award: Grant
Awardee: Thurston-Mason County Medical Society - VCI
1800 Cooper Point Road SW, #7-A
Olympia, WA 98502

Status: This project is underway; the notification letter was sent June 27, 2008.

Description: The mission of Thurston County Project Access (TCPA) is to provide access to urgent medical care to residents of Thurston County who are at, or below, 200% of the Federal Poverty Level, and are currently uninsured or underinsured. ■

Ticket to Work Initiatives

Project No: 500-00-0047/05
Project Officer: Joseph Razes
Period: May 2006 to May 2008
Funding: $1,853,273.00
Principal Investigator: Dr. Su Lui
Award: Task Order (RADSTO)
Awardee: Mathematica Policy Research, (DC)
600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512

Status: This contract has ended and a new contract was awarded in 2008 to Mathematica Policy Research, Inc. to continue on with the Medicaid Buy In evaluation.

Description: The purpose of this project is to evaluate the effectiveness initiatives contained in the Ticket to Work and Work Incentives Improvement Act of 1999. Section 201 of the Act expanded the eligibility for Medicaid to workers with disabilities (Medicaid Buy-In or MBI). In conjunction with Section 201, Section 203 provides grants to States to establish infrastructures that support working individuals with disabilities. These efforts require that CMS focus on two types of outcomes: employment and health status. The Medicaid Infrastructure Grant (MIG) program requires that CMS, in consultation with the Ticket to Work and Work Incentives Advisory Panel, report on the effectivness of the MIG program and whether it should be continued. This project will provide a coherent national analysis of the establishment of and enrollment in the State MBIs. The research files, thus created, will provide for a longitudinal analysis of the MBI efforts. ■

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

Project No: HHSM-500-2006-00006I/15
Project Officer: Todd Caldis
Period: September 2008 to September 2009
Funding: $149,980.00
Principal Investigator: Thomas MaCurdy
Award: Task Order (XRAD)
Awardee: Acumen, LLC
500 Airport Blvd. Suite 365
Burlingame, CA 94010

Status: The kick off has occurred and the contractor is at work on the literature review that is the first phase of the contract.

Description: The purpose of this task order is to determine the immediate potential of time series methods and related economic forecasting methods as tools for improving long-range forecasts of health expenditures. By critically evaluating the existing research literature for forecasting aggregate health expenditures, as well as by developing a research agenda in consultation with the Office of the Actuary concerning time series/economic forecasting of aggregate health expenditures, and by completing forecasting studies to be agreed upon with the Office of the Actuary. ■

Time Study Project Data Collection and Analysis

Project No: 500-02-0030/02 & HHSM-500-2008-00072C
Project Officer: Kathryn Jansak
Jeanette Kranacs
Period: September 2005 to January 2010
Funding: $7,071,537.00
Principal Investigator: Jean Eby
Award: Task Order
Awardee: Iowa Foundation for Medical Care
6000 Westown Parkway
West Des Moines, IA 50266

Status: The project has marked the basic completion of the first phase of this multi-state nursing home staff time measurement study (also known as Staff Time and Resource Intensity Verification (STRIVE)). The contractor has collected staff time and resident characteristic data on over 9,000 residents from 205 nursing homes across fifteen states and has incorporated that information into a useable database. Solidly into the second phase of the project, the contractor continues in-depth analysis of the data obtained to reevaluate the RUG-III model and recalibrate the case-mix weights.

Description: This contract was awarded to assure that payments to skilled nursing facilities (SNFs) remain accurate by reflecting current patient care practices, such as allocation of nursing home staff time to residents. Medicare reimburses Part A skilled nursing services on a prospective payment system (PPS), which uses the Resource Utilization Group, version three (RUG-III), case mix classification system to determine payments based on resident data. Introduced in 1998, the SNF PPS was constructed on the basis of staff time measurement studies conducted over a decade ago (in 1990, 1995, and 1997). Preliminary STRIVE analysis has suggested that industry practices have changed in some ways over the last decade. Continued analysis in this project will enable CMS to implement the newer information into the SNF PPS in a variety of ways. For instance, while the RUG model still accurately reflects differences in resource use in aggregate, we anticipate making updates to reflect utilization and practice changes that have occurred since the introduction of the original RUG model. Since about half of the states in the country use a version of the RUG-III system to determine payment rates for their Medicaid nursing homes, national data resulting from STRIVE analysis will be made available to State Medicaid agencies to evaluate their payment structures. CMS also plans to implement the revised RUG model resulting from the project under Medicare Part A effective October 1, 2009. This is the same date that CMS also plans to introduce its latest version of the assessment instrument--MDS 3.0--which STRIVE has analyzed to the extent its items collect resident characteristics necessary to case-mix classification under the RUG model. ■

Transparency and Public Reporting: Consumer Testing of Enhancements to CMS' Compare Tools

Project No: HHSM-500-2006-00009I/08
Project Officer: David Miranda
Period: September 2008 to September 2009
Funding: $1,052,028.00
Principal Investigator: Myra Tanamor
Award: Task Order (XRAD)
Awardee: L&M Policy Research
PO Box 42026
Washington, DC 20015

Status: The project is underway.

Description: This effort builds on earlier work consumer testing language and displays of quality measures for plans and providers. It also builds on efforts to provide transparency about CMS payments, costs, and charges; consumer out-of-pocket costs; and various provider characteristics, such as volume of service. The content may focus on health or drug plans, or providers such as hospitals, nursing homes, dialysis facilities, home health agencies, medical groups or physicians. ■

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

Project No: CMS-ORDI-2008-0002
Project Officer: Gerald Riley
Period: February 2007 to October 2008
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: Findings were published in the October 2008 issue of American Journal of Managed Care. Citation: Riley, G.F. Trends in Out-of-Pocket Health Care Costs Among Elderly Community Dwelling Medicare Beneficiaries. American Journal of Managed Care, vol. 14, no. 10, pp. 692-696, October 2008. Objective: To describe trends in out-of-pocket health care costs, including insurance premiums, for elderly Medicare beneficiaries living in the community. Specific questions include: 1) How much have out-of-pocket costs increased absolutely and relative to income? 2) Has the distribution of out-of-pocket costs changed over time? 3) How do costs vary by beneficiary characteristics such as income and health status? 4) To what extent do high out-of-pocket costs persist from year to year? Study design: Medicare Current Beneficiary Survey data were analyzed for community dwelling beneficiaries aged 65 or over, between 1992 and 2004. Methods: The primary focus of the analysis was out-of-pocket health care costs and out-of-pocket costs as a percent of income. Descriptive statistics are presented for four years: 1992, 1996, 2000, and 2004. Results: Inflation-adjusted median out-of-pocket costs were relatively stable between 1992 and 2000, then rose by 22 percent between 2000 and 2004. Costs as a percent of income declined between 1992 and 1996, but increased from 12.6 percent in 2000 to 15.5 percent in 2004. Out-of-pocket costs increased fastest at the upper percentiles of the distribution. High out-of-pocket costs tended to persist from year to year, exacerbating the financial burden for some beneficiaries. Conclusions: Following a period of declining burden between 1992 and 1996, out-of-pocket health care costs rose significantly between 2000 and 2004, increasing the financial burden for many elderly Medicare beneficiaries. These data provide a baseline for evaluating the impact of Medicare reform proposals that may impact beneficiary spending.

Description: Medicare Current Beneficiary Survey data were used to examine trends in out-of-pocket health care costs incurred by elderly community dwelling Medicare beneficiaries between 1992 and 2004. ■

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

Project No: CMS-06-110106
Project Officer: Gerald Riley
Period: November 2006 to October 2008
Funding: $ 0.00
Principal Investigator: Gerald Riley
Award: Intramural
Awardee: Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Status: An article was published in "The American Journal of Managed Care" in October of 2008. The project is now complete.

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

Utah Primary Care Network

Project No: 11-W-00145/08
Project Officer: Kelly Heilman
Period: February 2002 to June 2010
Funding: $ 0.00
Principal Investigator: Michael Hales
Award: Waiver-Only Project
Awardee: Utah, Department of Health (Box 143108)
288 N. 1460 West, 3rd Floor, P.O. Box 143108
Salt Lake City, UT 84114-3108

Status: As of 9/30/2008, 35,953 individuals participated in the demonstration. Of these, 17,017 were parents and caretaker relatives who were eligible under the Medicaid State Plan and who were receiving reduced benefits under the demonstration; 18,374 were adults receiving the limited primary and preventive care benefit or assistance to with employer sponsored insurance premiums; and 562 were SCHIP-eligible children receiving premium assistance in lieu of SCHIP coverage.

Description: Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage to certain able-bodied State plan eligibles who are categorically or medically needy parents or other caretaker relatives. For these State plan populations, the demonstration provides a reduced benefits package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 and older with incomes up to 150% FPL. This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also, high risk pregnant women, whose resources made them ineligible under the State plan, are covered under the Demonstration for the full Medicaid benefits package. The PCN Demonstration was amended in October 2006 to offer assistance with payment of premiums for employer-sponsored health insurance (ESI) for up to 1,000 uninsured, low-income (up to 150% FPL) working adults and up to 250 SCHIP-eligible children of such adults. ■

Virginia Family Planning

Project No: 11-W-00152/3
Project Officer: Lane Terwilliger
Period: July 2002 to September 2010
Funding: $ 0.00
Principal Investigator: Patrick Finnerty
Award: Waiver-Only Project
Awardee: Virginia, Department of Medical Assistance Services
600 East Broad St, Suite 1300
Richmond, VA 23219

Status: As of 6/30/2008, 7,870 individuals received family planning services through this demonstration.

Description: This demonstration extends eligibility for family planning services to women who would lose Medicaid eligibility at the end of 60 days post-partum and to men and women of childbearing age with family income up to 133% FPL. ■

Waiver Management System Database and Grant On-Line Management System

Project No: 500-00-0021/04
Project Officer: Herbert Thomas
Period: August 2005 to December 2008
Funding: $4,079,117.00
Principal Investigator: Majorie Hatzman
Award: Task Order (RADSTO)
Awardee: MEDSTAT Group (DC - Conn. Ave.)
4301 Connecticut Ave., NW, Suite 330
Washington, DC 20008

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

Description: The purpose of this Task Order is to collect accurate data, and analyze it in a timely manner. The Waiver Management System (WMS), in line with E-GOV initiatives, is critical to the transformation of a current paper-based process to a more efficient electronic system. The WMS system has been developed to

manage Medicaid program information in a Web-based data warehouse. Web and e-mail tools will facilitate workflow automation through direct report submissions, notifications and alerts making the process more efficient for States and the Federal government. The Grant On-line Management Database (GMD) System was developed and implemented under this Task Order to facilitate implementation, progress and quality reports on specific grant programs. ■

Washington "Take Charge" Demonstration

Project No: 11-W-00134/0
Project Officer: Lane Terwilliger
Period: March 2001 to June 2009
Funding: $ 0.00
Principal Investigator: Doug Porter
Award: Waiver-Only Project
Awardee: Health and Recovery Services Administration
P.O. Box 45502
Olympia , WA 98504-5050

Status: As of 9/30/2008, 123,526 individuals received family planning services through Washington's "Take Charge" family planning demonstration.

Description: The purpose of the demonstration is to provide family planning services to uninsured men and women of childbearing age who are not otherwise eligible for Medicaid, SCHIP, or Medicare, and who have family income at or below 200% FPL. ■

Wisconsin Family Planning

Project No: 11-W-00144/5
Project Officer: Lane Terwilliger
Period: June 2002 to December 2010
Funding: $ 0.00
Principal Investigator: Jason Helgerson
Award: Waiver-Only Project
Awardee: Wisconsin Department of Health and Family Services
1 West Wilson Street, Room 350
Madison, WI 53701

Status: As of 9/30/2008, 57,382 individuals received family planning services through the demonstration.

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

Wyoming "Pregnant By Choice" Demonstration

Project No: 11-W-00238/8
Project Officer: Lane Terwilliger
Period: September 2008 to August 2013
Funding: $ 0.00
Principal Investigator: Teri Green
Award: Waiver-Only Project
Awardee: Wyoming, Department of Health
6101 N. Yellowstone Road, Room 259B
Cheyenne, WY 82002

Status: The Wyoming "Pregnant By Choice" Demonstration was approved 9/18/2008, and was implemented 10/1/2008.

Description: The Wyoming "Pregnant By Choice" Demonstration provides coverage for family planning services to all uninsured women age 19-44 with family incomes at or below 133% FPL who are not otherwise eligible for Medicaid, SCHIP, or Medicare. ■

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