DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-5015-N]

Medicare Program; Care Management for High-Cost Beneficiaries (CMHCB) Demonstration

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice informs eligible health care organizations of an opportunity to apply to implement and operate a care management demonstration serving high-cost beneficiaries in the original Medicare fee-for-service (FFS) program. This voluntary demonstration is part of an effort to develop and test multiple strategies to improve the coordination of Medicare services for high-cost FFS beneficiaries. The notice contains information on how to obtain the complete solicitation and supporting information.

EFFECTIVE DATE: Applications will be considered timely if we receive them on or before January 4, 2005.

ADDRESS: Mail applications to—

Centers for Medicare & Medicaid Services

Attention: Cynthia Mason
Mail Stop: C4-17-27
7500 Security Boulevard
Baltimore, Maryland 21244.

Because of staff and resource limitations, we cannot accept applications by facsimile (FAX) transmission or by e-mail.

FOR FURTHER INFORMATION CONTACT:

Cynthia Mason at (410) 786-6680 or cmhcbdemo@cms.hhs.gov

SUPPLEMENTARY INFORMATION:

I. Background

The Department of Health and Human Services is developing and testing multiple strategies to improve the coordination of Medicare services for beneficiaries with high-cost conditions. However, one approach that remains to be studied is intensive management for high-cost beneficiaries with various medical conditions to reduce cost as well as improve

quality of care and quality of life for those beneficiaries. Therefore, we are interested in proposals to restructure care or enhance the management of care for beneficiaries with costly medical conditions. It is anticipated that organizations will serve high-risk beneficiaries with a variety of medical conditions and that the vast majority of beneficiaries participating in the demonstration will have multiple conditions. One organization will be selected per area to offer services to eligible beneficiaries. Beneficiary participation in the programs will be voluntary and will not change the amount, duration or scope of participants' fee-for-service (FFS) Medicare benefits. FFS Medicare benefits will continue to be covered, administered, and paid under the traditional Medicare FFS program. Programs will be offered at no charge to the beneficiary. Organizations chosen for the demonstration will not be able to restrict beneficiary access to care (for example, there can be no utilization review or gatekeeper function) or restrict beneficiaries to a limited number of physicians in a network.

Applicants may propose to serve one or more areas, but their proposed service areas must be adjusted to ensure that the population is of an appropriate size that would ensure statistically significant results. Also, to avoid any overlap between the current FFS care management demonstrations or the Chronic Care Improvement Programs (CCIP), it will be necessary to exclude from the Care Management for High-Cost Beneficiaries (CMHCB) demonstration population any beneficiaries who meet the criteria to participate in existing demonstrations or CCIP.

Organizations may be paid a monthly fee per participant or participate under a gain-sharing arrangement based on Medicare savings; however, fee and gain-sharing payments will be contingent on improvements in clinical quality of care, beneficiary and provider satisfaction, and savings to Medicare in the intervention groups compared to control groups.

II. Provisions of This Notice

This demonstration is intended to test models of care management for high-cost beneficiaries under the Medicare FFS program, incorporating relevant features from traditional disease management programs, but allowing sufficient flexibility for us and the awardees to adapt the design of

CMHCB programs to meet the unique needs of the high-cost Medicare population. For some beneficiaries with high-cost conditions, the restructuring of the care management plan to integrate provider services in the program and to deliver those services in non-acute care locations such as the beneficiary's home could significantly improve the beneficiary's quality of life while simultaneously reducing costs. Under the CMHCB demonstration, we hope to test a variety of models such as intensive case management, increased provider availability, structured chronic care programs, restructured physician practices, and expanded flexibility in care settings to deliver care to high-cost beneficiaries with multiple conditions.

The organization(s) that are awarded the demonstration project will be required to agree to assume financial risk in the event of failure to meet agreed upon performance guarantees for clinical quality, beneficiary and provider satisfaction and savings targets. That financial risk will include all fees and gain-sharing payments.

Organizations eligible to apply to implement and operate care management programs under CMHCB include--

- Physician groups;
- Hospitals; or
- Integrated delivery systems.

Other organizations may apply, but only as part of a consortium that includes physician groups, hospitals, or integrated delivery systems that would play a major role in the operation of the proposed CMHCB demonstration. Eligible organizations must be capable of providing ambulatory health care services.

We plan to make approximately four to six awards. Interested parties can obtain complete solicitation and supporting information on the CMS website at http://www.cms.hhs.gov/researchers/demos/cmhcb.asp. Paper copies can be obtained by writing to Cynthia Mason at the address listed in the "ADDRESS" section of this notice.

III. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the

collection is currently approved under OMB control number 0938-0880 entitled “Medicare Demonstration Waiver Application” with a current expiration date of 7/31/2006.

Authority: Section 402(a)(1)(B) and (a)(2) of the Social Security Amendments of 1967, Pub. L. No. 90-248, as amended, 42 U.S.C. § 1395b-1(a)(1)(B) and (a)(2). (Catalog of Federal Domestic Assistance No. 93.773 Medicare-Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: _____

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Mark B. McClellan,
Administrator,
Centers for Medicare & Medicaid Services.

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