DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4043–N]

RIN 0938–ZA37

Medicare Program; Solicitation for Proposals for the Physician Group Practice Demonstration

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

ACTION: Notice for solicitation of proposals.

SUMMARY: This notice informs interested parties of an opportunity to apply to participate in the Medicare Physician Group Practice Demonstration. The goal of the demonstration is to encourage coordination of Part A and Part B services; promote efficiency by investment in administrative structures and care processes; and reward physicians for improving health outcomes. A competitive process will be used to select up to six health care groups to participate in the 3-year demonstration.

DATES: Applications will be considered timely if we receive them on or before December 26, 2002.

ADDRESSES: Applications should be mailed to the following address: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Attention: John Pilotte, Project Officer, Center for Beneficiary Choices, DDAG/DDP, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

General Information: Please refer to file code CMS–4043-N on the application. Applications (an unbound original and 2 copies plus an electronic copy) must be typed for clarity and should not exceed 40 double-spaced pages, exclusive of cover letter, the executive summary, resumes, forms, and supporting documentation.

Because of staffing and resource limitations, we cannot accept applications by facsimile (FAX) transmission. Applications postmarked after the closing date, or postmarked on or before the closing date but not received in time for the panel review, will be considered late applications.

Eligible Organizations: Health care groups with at least 200 physician full-time equivalents are eligible to apply. Candidates must meet the criteria outlined in section III.B of this notice.

FOR FURTHER INFORMATION CONTACT: John Pilotte at (410) 786–6558, or by e-mail at *Jpilotte@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. Statutory Requirements

Section 412 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) amends title XVIII of the Social Security Act by establishing the Physician Group Practice (PGP) Demonstration.

The PGP demonstration tests a hybrid payment methodology that combines Medicare fee-for-service payments with a bonus pool derived from savings achieved through improvements in the management of patient care and services by physician groups and affiliated organizations.

As defined under BIPA, the goals of the PGP demonstration are to—(1) Encourage coordination of Part A and Part B services; (2) promote efficiency by investment in administrative structures and care processes; and (3) reward physicians for improving health outcomes.

The BIPA mandate along with recent changes in the commercial market create a timely opportunity for us to implement a demonstration giving physician groups incentives for coordinating care, increasing efficiency, and improving processes and outcomes.

B. Issue

The PGP demonstration will enable us to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

Physicians influence, either directly or indirectly, almost all areas of Medicare spending. For example, physicians deliver services, admit beneficiaries to hospitals, and authorize home health visits. The PGP demonstration seeks to align incentives for physician groups to manage the overall care of its patients. The PGP demonstration encourages health care groups to attract, retain, and coordinate care to beneficiaries; gives physicians incentives to provide services efficiently to their patients; provides a framework in which we can collaborate with providers to the advantage of Medicare beneficiaries; and promotes active use of utilization and clinical data for the purpose of improving efficiency and outcomes.

C. Financial Incentives

Managed care incentive-based payment models evolved as a means to combat rising health care costs, initially focusing on rewarding physicians for financial performance, and have recently focused on incorporating incentives for quality performance.

The Institute of Medicine report entitled, *Crossing the Quality Chasm: A New Health System for the 21st Century* (published by Health Care Services, National Academy Press in 2001), found that quality-related problems can result in waste and lead to inefficiencies, directly conflicting with incentives designed to reduce costs. Therefore, we need a more direct alignment between the compensation method and quality improvement initiatives, especially for individuals with chronic illness who account for a significant portion of Medicare spending.

The PGP demonstration provides the opportunity to identify, test, and evaluate aligning health care providers compensation models with quality improvement goals in the Medicare fee-for-service environment.

II. Physician Group Practice Demonstration

A. Overview

The PGP demonstration will provide a unique reimbursement mechanism through which providers are rewarded for coordinating and managing the overall health care needs of a nonenrolled, fee-for-service patient population. It offers an opportunity to test whether a different financial incentive structure can improve service delivery and quality for Medicare patients, and ultimately prove cost-effective.

The PGP demonstration superimposes new incentives on traditional fee-for-service reimbursement that are more in line with those used by managed care organizations and other commercial payers. In addition, the PGP demonstration includes explicit incentives for process and outcome improvement. Performance on both process and outcome quality indicators, together with cost savings, will be used in the calculation of performance bonuses.

Under the 3-year demonstration, health care groups will continue to be paid under the existing Medicare fee schedules. Health care groups will be able to earn a bonus from a portion of any savings realized relative to their performance target.

Annual performance targets will be calculated for each participating health care group at the end of the performance year, as soon as complete data are available. The target will be derived from a base expenditure amount equal

to the average total payments under Part A and Part B. The performance target is calculated based on services furnished by the health care group on a fee-for-service basis during a base period, adjusted for risk and expected growth rates.

Bonus payments will be allocated between efficiency improvements and documented improvements in processes and outcomes. Bonus payment will be made to a single entity (health care group). The entity is responsible for allocating any bonus payments among affiliated organizations.

Participating health care groups must notify beneficiaries of the incentive arrangement. Medicare balance billing rules continue to apply as well as beneficiary deductibles and coinsurance.

Bonus payments made to demonstration participants must be derived from savings produced by participating organizations. Below, we describe the methodology that will be used to calculate savings and bonuses.

B. Calculating Savings and Bonuses

Under the 3-year demonstration, PGPs and affiliated providers will continue to bill and be paid standard Medicare fee-for-service reimbursement. PGPs will not assume risk for their Part A and Part B payments under the demonstration. PGPs and affiliated providers participating in the demonstration will also be eligible to earn an annual performance bonus.

Bonuses will be paid from a bonus pool derived from Medicare savings generated by the PGP. Medicare savings and bonuses will be calculated after the end of the performance year and as soon as complete data are available. Consequently, bonuses are not likely to be computed and paid until 9 to 12 months after the end of the performance period due to claims lag and operational complexities involving data volume.

PGPs will not receive actual performance targets at the beginning of the performance year. However, PGPs will receive Medicare fee-for-service per-capita expenditures for their market area, in addition to hospital utilization data at the beginning of the performance period, and, thereafter, on an interim basis that they may use to monitor their performance in relation to the market area.

1. Bonus Payment Methodology

The following summarizes the key steps involved in calculating savings to fund financial quality bonuses. The BIPA section 412 refers to incentive and process and outcome improvement bonuses. Throughout this document, we use the term ''quality'' bonus to refer to the process and outcome improvement bonus and ''financial'' to refer to the incentive bonus as outlined in the BIPA.

a. We will identify the immediate market area in which the PGP derives its beneficiaries. The market area will be defined as counties in which 1 percent or more of the beneficiaries assigned to the PGP reside. Only counties from the State in which the PGP is located or in contiguous States for PGPs serving regional populations will be included. The counties will be used to calculate the per-capita Medicare fee-for-service growth rate for the market area that will be used in setting the PGP's performance target.

b. We will use claims data to assign Medicare beneficiaries to the PGP. Beneficiaries who receive at least one evaluation and management (E&M) service from a participating PGP will be eligible for assignment to the PGP. Beneficiaries who receive more E&M services (as measured by Medicare expenditures) from the PGP than from any other physician practice (group or solo) will be assigned to the PGP. For beneficiaries assigned to a PGP in the base year, the base year per-capita expenditures will be calculated.

c. An expenditure target for the performance year will be calculated as follows:

- Target = (Adjusted Base Year Per-Capita Expenditures) × (1 + Expected Growth Rate).

Per-capita expenditures in the base year will be adjusted to account for differences in the case-mix of beneficiaries assigned to the PGP in the performance year. The adjusted base year per-capita expenditures will be updated by the PGP's expected growth rate, that is the growth rate in per-capita expenditures for the PGP's local market area, adjusted for case-mix change.

d. Medicare savings will be computed as the difference between the expenditure target and the PGP's per-capita expenditures in the performance year (for beneficiaries assigned to the PGP in the performance year), multiplied by the number of beneficiaries assigned to the PGP in the performance year. The following is how the calculations will be performed:

- Medicare Savings = (Target—Performance Year Per-Capita Expenditures) x (Assigned Beneficiaries).

e. If a PGP is below its expenditure target, the bonus pool for the PGP is a portion of the savings it generates for Medicare and will be calculated as follows:

- Bonus Pool = (Medicare Savings) x (Sharing Rate).

The sharing rate is equal to 80 percent and represents the proportion of the Medicare savings that funds the PGP's bonus pool. The Medicare Trust Funds will retain the remaining 20 percent.

f. The PGP bonus pool will be allocated between financial performance and quality performance and will be calculated as follows:

- Earned Bonus = (70 percent financial performance + 30 percent maximum quality bonus) x (withhold).

PGPs will receive 70 percent of the bonus pool solely due to financial performance. The remaining 30 percent will be available to the PGP as a quality bonus. The actual quality bonus earned by the PGP equals the maximum quality bonus multiplied by the percentage of quality targets met by the PGP (for example, if the PGP satisfies four of eight quality measures, it will earn 50 percent of the maximum quality bonus). Any amount of the maximum quality bonus that is not earned by the PGP will be additional savings for the Medicare Trust Funds. The earned bonus to the PGP will be subject to an annual 25-percent withhold that the Medicare Trust Funds will reserve to cover losses (for example, PGP actual expenditures > performance target) incurred by the PGP in future years. At the end of the 3-year demonstration, positive balances in the withhold account will be payable to the PGP.

2. Bonus Payment Example

The following example illustrates how savings will be calculated and bonuses awarded. The actual amounts will vary with performance. The example assumes expenditure growth rates of 3 percent for the beneficiaries assigned to the PGP and 8 percent for the local market (5-percent savings by the PGP); 30,000 assigned Medicare fee-for-service beneficiaries; an 80 percent sharing rate; a 25-percent withholding rate; and half (four of eight) of the quality targets are met.

TABLE 1.—EXAMPLE OF A BONUS CALCULATION

Bonus calculation process	Bonus award
Target Per-Capita Expenditures	$7,020
PGP Site Per-Capita Expenditures	6,695
Medicare Savings Per-Capita Expenditures	325
Total Medicare Savings	9,750,000
Medicare Trust Funds Savings	1,950,000
Bonus Pool	7,800,000

TABLE 1.—EXAMPLE OF A BONUS CALCULATION—Continued

Bonus calculation process	Bonus award
Total Bonus	6,630,000
Financial Performance	5,460,000
Quality Performance	1,170,000
Withhold	1,657,500
Earned Bonus	4,972,500

In Table 1, the total annual Medicare program savings is $9,750,000 or per-capita savings of $325 multiplied by the total number of beneficiaries (30,000) assigned to the PGP. The Medicare Trust Funds will retain 20 percent of the total savings, which is equal to $1,950,000. The remaining 80 percent of Medicare savings is available through the bonus pool. The bonus for financial performance is equal to 70 percent of the bonus pool or $5,460,000. The remaining 30 percent of the bonus pool or $2,340,000 is available to the PGP based on its performance on the quality measures. In this example, the PGP satisfies only four of the eight quality measures and earns only $1,170,000 or half of the $2,340,000 available for quality performance.

The total bonus for the PGP is $6,630,000 consisting of $5,460,000 for financial performance and $1,170,000 for quality performance. The total bonus is subject to a 25-percent withhold or $1,657,500 to offset any future losses. The bonus earned (and payable) to the PGP for the performance year is $4,972,500, which is equal to the total bonus minus the withhold.

3. Bonus Payments

PGPs will have up to 3 years to generate savings and earn a bonus. After 3 years, performance targets will be rebased if the demonstration continues. Bonuses may be earned by participating PGPs in performance years in which the organization has generated Medicare savings. Losses in performance years in which there are no Medicare savings accrue to PGPs and bonuses will be reduced in subsequent years to cover any losses.

The maximum bonus that can be earned by a PGP in a year (bonus payments plus withhold amount) is limited to 15 percent of target Medicare expenditures for beneficiaries assigned to that organization in that year. If a participating PGP withdraws from the demonstration before the end of the 3-year period, it is required to remit to us the full amount of any demonstration bonus payments it has received.

4. Interim Utilization Performance Reporting

We plan to provide interim utilization performance reports for participating PGPs. The report will give participating PGPs timely feedback about their performance. Due to data availability and processing lags, reconciliation of the PGPs' financial performance in relation to their target for the year will not occur until 9 to 12 months following the end of the performance year.

5. Demonstration Milestone

The following table illustrates how we intend to provide the interim utilization performance reports and award bonus payments to PGPs under the demonstration. Bonus payments will not be made until 9 to 12 months after the end of the performance year, due to data lags and processing issues. However, we will provide PGPs' with interim performance reports including key utilization indicators as close to the end of the performance year as possible.

TABLE 2.—BONUS PAYMENT AND REPORTING MILESTONES

	Base year	Performance year 1	Performance year 2	Performance year 3	Post demonstration year
Performance Report	►	▼	▼	▼	
Bonus Payment			▲	▲	▲

► = Demonstration starts.
▼ = Interim utilization performance reports.
▲ = Bonus payment.

C. Demonstration Design Summary

The PGP demonstration presents numerous operational challenges for us. The following discusses several key issues with the payment methodology and how we plan to adjust for them in implementing the demonstration. For more information on the payment methodology, go to our website at *http://www.cms.hhs.gov/healthplans/research* and select the ''Physician Group Practice Demonstration.''

1. Assigning Beneficiaries to PGPs

A PGP's ability to coordinate and manage the health care of a beneficiary depends on the types of services the PGP provides to the beneficiary, and the overall control the PGP has over the beneficiary's utilization of services. Since the PGP demonstration is a fee-for-service innovation, there is no enrollment process whereby beneficiaries accept or reject involvement. Therefore, beneficiaries need to be assigned to PGPs based on utilization of Medicare-covered services.

A beneficiary who receives at least one E&M service from a participating PGP is eligible for assignment to the PGP. If the beneficiary receives more E&M service (as measured by Medicare expenditures) from the PGP than from any other physician practice (group or solo), then the beneficiary is assigned to the PGP.

Therefore a beneficiary is assigned to no more than one PGP under the demonstration. This prevents us from paying bonuses more than once when multiple PGPs serve overlapping Medicare patient populations. Since many chronically ill beneficiaries receive their primary care from specialists rather than primary care physicians, E&M services provided by any physician are used for assignment.

2. Base Expenditure Amount

BIPA requires that the PGP demonstration include ''a base expenditure amount, equal to the average total payments under Parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary.'' All Part A and Part B Medicare claims will be used to calculate the base expenditure amount, the performance target, and the physician group's actual experience. The base expenditure amount will be derived from all Part A and Part B Medicare claims from the 12-month period preceding the performance period.

All Medicare expenditures are the most comprehensive basis for the PGP base expenditure amounts, and this basis is consistent with the BIPA requirement. Since the goal of the PGP demonstration is to encourage

coordination of Part A and B services, promote efficiency, and reward physicians for improving health outcomes, setting a comprehensive target gives the PGP more flexibility to focus on the largest sources of inefficiency.

3. Comparison Population

The comparison population for a participating PGP consists of fee-for-service Medicare beneficiaries residing in the PGP's local market area that are not assigned to the PGP. The PGP's market area will consist of all counties in which the group derives at least 1 percent of its Medicare beneficiaries. These counties will be combined to form the market area for the group. We will use claims and beneficiary enrollment data to identify the county of residence of all beneficiaries treated by the group.

The market area is defined for both base and performance years, and may differ between the 2 years to reflect changes in the PGP's service area. The PGP's expected expenditure growth rate is the change in market area per-capita expenditures from the base to the performance year. Market area per-capita expenditures is defined as weighted average county per-capita expenditures of market area counties. The weights are the share of participating PGP beneficiaries residing in each market area county.

4. Sharing Rate

The sharing rate is the maximum proportion of the Medicare savings generated by a PGP that can be paid to the PGP as a bonus. The sharing rate needs to be high enough to give PGPs sufficient incentive to participate in the demonstration, but low enough so that the Medicare program shares significantly in any savings.

The sharing rate will be set at 80 percent for all participating PGPs. With this sharing rate, the PGP may earn up to 80 percent of the Medicare savings it generates depending on its performance with regard to the quality of care targets. The remaining 20 percent will accrue to the Medicare Trust Funds.

5. Health Status Case-Mix Adjustment

To make comparisons between participating PGP and comparison group expenditure growth rates, health status case-mix needs to be held constant. The per-capita expenditures of both participating PGPs and their comparison groups are adjusted for case-mix using the concurrent Diagnostic Cost Groups, Hierarchical Condition Categories (DCG–HCC) model. This model uses diagnoses on Medicare claims (for example, inpatient, outpatient, and physician) to predict the expected average expenditures of a population based on its health status. The model is concurrent, and explains expenditures in the current year.

The DCG–HCC model is part of the same family of DCG models as the model that is currently used for risk adjustment of capitation payments to Medicare+Choice (M+C) plans. However, it differs in two key respects from the Principal Inpatient Diagnostic Cost Group model used in M+C payment. First, since ambulatory diagnoses are available from Medicare fee-for-service claims, the DCG–HCC model is more comprehensive. Second, the DCG–HCC model is concurrent, meaning that it forecasts expenditures in the current year and better reflects market changes.

6. Thresholds for Bonus Payment

A bonus threshold avoids paying a bonus for small differences in site versus comparison population (market area) expenditure growth rates that could be due to chance. Choosing an appropriate bonus threshold involves the probabilities of paying deserved bonuses versus not paying undeserved bonuses.

Based on simulations, a bonus threshold of 2 percent will be used. This means that a bonus would not be paid unless the difference in the site and market expenditure growth rates exceeds 2 percent. However, if the threshold is exceeded, the full bonus will be paid.

7. Rebasing

Rebasing means changing the base year for the PGP bonus calculation. Over the relatively short period of the demonstration (3 years), PGPs will not be rebased. If bonuses are allowed to accumulate, gains and losses, which are random to some extent, can offset each other to measure long-run cost control performance more accurately.

If the demonstration is continued past 3 years, the base year will be updated so that the Medicare program can capture more of PGP cost savings, and PGPs will not be rewarded indefinitely for past performance. Other demonstration policies may also be subject to change if the demonstration is continued past 3 years.

8. Withhold

Over the course of the demonstration, a participating PGP may accrue bonuses in some years and losses in other years, perhaps due to chance. The issue is whether full (positive) bonuses should be paid in the year they are accrued, or whether some portion should be withheld to offset future losses (for example, PGP actual expenditures exceed the performance target) in order to avoid having to recover payments from a PGP.

A flat 25 percent withholding rate will be applied annually to the bonus before payment. At the end of the demonstration, positive balances will be returned to the PGP.

9. Cost Outliers

Random variability of expenditure growth rates for PGP demonstration participants or their comparison populations may lead to a lack of savings even when participants are reducing services per beneficiary. There is the chance that a small group of extremely costly beneficiaries will be assigned to a PGP and could significantly change a PGP's per-capita expenditures and, hence, its bonus.

Thus, for each beneficiary assigned to a PGP or comparison group, annualized expenditures will be capped in calculating savings to avoid contamination by cost outliers. Capping expenditures will give PGPs an incentive to coordinate and manage the health care of the majority of patients assigned to them, while not penalizing the group for high-cost outliers or providing incentives to under use services for beneficiaries with highly complex conditions.

In 1997, more than 99 percent of Medicare fee-for-service beneficiaries had annualized expenditures of less than $100,000. In calculating savings, a beneficiary's expenditures will be capped at $100,000.

D. Quality Improvement Bonuses

The PGP demonstration allows for financial incentives for improving patient care process and outcomes. The BIPA states that ''at such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group, * * * an additional bonus for a year, equal to such portion as the Secretary may designate of the savings to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.''

We believe that the PGP's ability to manage patient care, especially chronic conditions afflicting Medicare beneficiaries, is critical to the group's ability to generate savings under the demonstration and, thus, be able to receive a bonus payment. We also recognize the numerous process and

outcome improvement activities that have been initiated by PGPs on their own to improve practice management and patient care as well as those initiated by commercial payers including private insurers, employers, and purchasing groups. Given the wide-ranging use of these indicators, we will work with PGPs to reduce administrative burdens and align incentives to the extent possible with other payers.

Under the demonstration, we will focus on linking financial incentives to improvements in process indicators of quality, although some outcome indicators will also be included. This is consistent with the BIPA 2000 mandate, and focuses on the quality indicators most easily measured, commonly used, and most relevant to the medical care operations of PGPs. We will reserve a maximum of 30 percent of the PGP bonus pool for bonuses related to quality improvement activities.

Medicare claims will be the primary data source for measuring quality indicators for the PGP demonstration. Using claims is low cost, reduces administrative burden on demonstration participants, and takes advantage of data already being used and available under the demonstration. Claims data will be used in calculating the PGP cost targets, performance comparisons, and Medicare savings for the bonus pool.

1. Process and Outcome Indicators

We will work with demonstration participants to select a group of core indicators for use in measuring process and outcome performance. Initially, we will seek to use eight process and outcome indicators. We will work with demonstration participants to identify a set of core measures that will be used uniformly for all participating PGPs. Measures will be agreed to by demonstration participants. Table 3 shows examples of process and outcomes performance measures.

TABLE 3.—PROPOSED PROCESS AND OUTCOME MEASURES

Quality indicator	Improvement target	Threshold target
Annual influenza vaccinations for all beneficiaries age 65 or older.	10% improvement over the deficit from 100% compliance.	75% compliance.
Hemoglobin A1c test every year for diabetics	10% improvement over the deficit from 100% compliance.	75% compliance.
Lipid profile test every 2 years for diabetics	10% improvement over the deficit from 100% compliance.	75% compliance.
Mammogram every 2 years for women aged 52–69	10% improvement over the deficit from 100% compliance.	75% compliance.
Chest radiograph and electrocardiogram <= 3 months after initial CHF diagnosis.	10% improvement over the deficit from 100% compliance.	75% compliance.
Left ventricular ejection fraction testing during the current year for beneficiaries hospitalized with a principal diagnosis of CHF during the current year.	10% improvement over the deficit from 100% compliance.	75% compliance.
Physician visit every 6 months for beneficiaries with chronic stable angina, COPD, CHF, or diabetes.	10% improvement over the deficit from 100% compliance.	90% compliance.
Rate of ACSC admissions per 1000 Medicare beneficiaries.	10% reduction from the previous year's rate	National average rate for FFS beneficiaries.

PGPs may also propose substituting two measures focused on process and outcome improvement activities that may be unique to their own practices. PGPs proposing process and outcome indicators should define the indicators and describe how they are used to improve physician performance, describe the process for evaluating and monitoring compliance (including examples of reports and profiles), and identify how aggregated Medicare claims data could be used to supplement or enhance the indicator and physician performance. Areas may include guideline compliance, patient safety initiatives, and chronic conditions impacting Medicare beneficiaries.

2. Targets for Earning a Quality Bonus

PGPs will have two different types of targets that they can meet to earn a quality bonus. Targets for quality measures will be based on either demonstrating improvement over time or achieving a predetermined threshold level for a quality indicator as described in the table above. Compliance with the indicator is met if either target is satisfied.

For example, a PGP could earn a bonus under the Hemoglobin A1c measure if—(1) At least 75 percent of the eligible beneficiaries assigned to the PGP receive the test during the performance year; or (2) the PGP demonstrates a 10-percent improvement over the prior year.

Improvement targets will be set using the following methodology that bases the target on improvements in the ''quality deficit.'' The quality deficit is defined as 100 percent minus the PGP's actual rate for assigned beneficiaries.

For example, if 30 percent of a PGP's diabetics had Hemoglobin A1c's tested in 1 year, it would have to raise that level to 37 percent the following year to demonstrate it had met the quality improvement target for that indicator. For example, a 70 percent deficit means a 7-percent improvement is required.

Allowing PGP's to earn bonuses by meeting or exceeding either pre-defined thresholds or improvement targets will give flexibility to PGPs, require bigger improvements for low performers than high performers, and take into consideration that it may be more difficult to improve on already high performance.

3. Calculating Quality Improvement Bonuses

Thirty percent of the PGP's bonus pool will be set aside for bonuses for PGP's meeting targets for process and outcome improvement measures. The actual bonus payment for process and outcome improvements is dependent on the number of measures that the group meets or exceeds the performance target.

For example, if eight measures are used, each measure would be worth 1/8 of the bonus pool for quality improvements. If the PGP satisfies compliance targets for four of the eight performance measures, its bonus would be 50 percent of the quality improvement bonus pool. If the PGP satisfies compliance targets for all eight measures, it would receive 100 percent of the quality bonus pool (for example, a full 30 percent).

E. Budget Neutrality

BIPA states ''the Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.''

Because of this requirement, bonuses will be paid from savings that the PGP generates from efficiency process and outcome improvements. Savings will be calculated using the methodology described in section II.B of this notice.

F. Demonstration Administration

Section 412 of the BIPA allows CMS to administer the demonstration program through a contract with a program administrator. At this time, we believe that it would be costly and not add value to use an external demonstration administrator. The demonstration can be more efficiently and effectively implemented by CMS given the extensive work already completed by the design and implementation contractors, CMS staff, the small scale of the demonstration, and the need to understand the linkages between payment incentives and improvements in process and outcome improvements. If CMS were to implement this program on a national scale, the additional resources and expertise of an external program administrator would be warranted.

G. Independent Evaluation

CMS will assess the impact of the demonstration on Medicare beneficiaries, physicians, and Medicare program costs as well as administrative burden through an independent evaluation. The evaluation will be conducted by CMS through an independent contractor. Demonstration participants must agree to cooperate fully with the independent evaluation contractor.

III. Provisions of This Notice

A. Purpose

This section outlines the requirements for eligible health care groups seeking to apply for the demonstration and application and submission requirements.

B. Eligible Organizations

Health care groups with at least 200 physician full-time equivalents may apply. Physician means any individual who furnishes services that may be paid for as physicians' services under the Medicare program. A health care group is defined as a group of physicians organized, at least in part, for the purpose of providing physicians' services under the Medicare program and may include a hospital and any other individual or entity furnishing services covered under the Medicare program that is affiliated with the health care group under an arrangement structured so that the individual or entity participates in the demonstration and shares in any bonus.

We are focusing the demonstration on large physician group practices. These organizations influence a significant amount of Medicare expenditures and have sufficient Medicare beneficiary volume to provide greater statistical reliability in calculating Medicare savings and/or losses under the demonstration.

We are seeking several different types of physician group practices to test the new incentives in a range of organizational and clinical environments. Eligible organizations include freestanding multispecialty physician group practices, faculty group practices, and physician groups that are part of health care systems, medical centers, or that have affiliations with hospitals and/or other providers.

Physician group practices that can respond effectively to the demonstration's new incentives are encouraged to apply. In particular, multispecialty physician groups with well-developed information and clinical and management systems should consider applying. We do not plan to make awards to health care groups currently participating in Medicare fee-for-service demonstrations.

C. Application Requirements

Applicants must submit their applications in the standard format outlined in CMS's Medicare Waiver Demonstration Application in order to be considered for review by the technical review panel. Applications not received in this format will not be considered for review.

The Medicare Waiver Demonstration Application follows this demonstration notice and may also be accessed at the following internet address: *http://www.cms.hhs.gov/healthplans/research*. The application outlines all application requirements including the format and content requirements. We note that the Medicare Waiver Demonstration Application is currently under review by the Office of Management and Budget (OMB) in regard to the Paperwork Reduction Act. Upon approval from OMB, we will update the application to denote OMB's approval.

1. Submission of Applications

We must receive applications (an unbound original and 2 copies plus an electronic copy) as indicated in the **DATES** and **ADDRESSES** sections of this notice. Only applications that are considered ''timely'' will be reviewed and considered by the technical review panel. Applications must be typed for clarity and should not exceed 40 double-spaced pages, exclusive of the cover letter, executive summary, resumes, forms, and supporting documentation.

2. Evaluation Process

We will convene technical review panels consisting of outside experts and our staff to review all of the proposals. Panelists will receive a copy of the proposals along with a technical summary. Panelists will be asked to numerically rate and rank the proposals and provide a written and oral assessment of the proposals using the following criteria.

3. Evaluation Criteria

Technical review panelists will assess and score applicants' responsiveness using the following evaluation criteria.

a. Organizational Structure (15 Points)

- A multispecialty physician group with at least 200 or more full time equivalent physicians.
- Administrative arrangements that are in place to share bonuses with any affiliated entities.
- The organization has capacity to provide and/or coordinate Part A & Part B services through Medicare participating or approved providers.

b. Leadership and Management (15 Points)

- The operations are managed by an executive whose appointment and removal are under the control of the organization's policy making body.
- The leadership has demonstrated the ability to influence and/or direct clinical practice to improve efficiency processes and outcomes.
- The organization has effective procedures to monitor use of appropriate health services and to control costs of health services to achieve utilization goals (for example, high cost case management and disease management).
- The organization has sufficient staff and systems to organize, plan, control, and evaluate the clinical financial and operations of the organization.

c. Financial Stability (10 Points)

- The current audited balance sheet shows a positive net worth.
- The current audited income statement shows sufficient cash flow and/or liquidity to meet financial obligations.
- The organization has a net operating surplus or acceptable financial plan for achieving.

d. Quality Assurance (20 Points)

- A physician directed quality assurance committee oversees an on-going action oriented quality assurance program. The committee is accountable for the quality assurance program and any delegated functions, and has processes for communicating activities to relevant parties.
- A quality assurance program establishes performance standards for quality of care and services, cost effectiveness, and process and outcome improvements.
- The quality initiatives are clearly defined and dedicated personnel are responsible for implementing, monitoring, and integrating changes into practice.
- The quality assurance methodology requires health outcome review of high volume and/or high-risk diagnosis or procedures, adverse outcomes and other quality of care related problems.
- Processes are in place for implementing and monitoring corrective action plans.

e. Process and Outcome Improvement (20 Points)

- Care coordination activities focus on diseases and conditions relevant to the Medicare population.
- Relevant process and outcome measures are monitored, performance assessed, and processes for sharing results and promoting accountability are in place.
- Information systems collect individual patient information and have the capacity to aggregate data to identify practice patterns and/or suspected aberrant care. Systems support both individual and pattern analysis and other quality assurance activities.
- The organization maintains a health record keeping system through which pertinent information relating to the health care of patients it serves is warehoused and is readily available to appropriate professionals.
- Patient safety is a focus of the organization with executive responsibility.

f. Demonstration Implementation Plan (20 Points)

- The organization understands demonstration principles and goals and objectives.
- The organization has clearly defined an implementation plan with measurable goals and objectives to improve efficiency, process and outcomes.
- The organization has sufficient infrastructure (for example, staff and systems) to implement, monitor, evaluate, and report on demonstration.
- The organization has successful results in implementing similar activities.

4. Final Selection

Our Administrator will select participants from among the most highly qualified candidates. Sites will be selected based on a variety of factors including organizational structure, operational feasibility, and geographic location. Awardees will be subject to our standard terms and conditions, and may be subject to special terms and conditions that are identified during the review process. We reserve the right to conduct site visits before beginning the demonstration. We expect to select up to six physician group practices to participate in the demonstration.

IV. Collection of Information Requirements

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We are, however, requesting an emergency review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320. We cannot reasonably comply with the normal clearance procedures because without the timely approval of this application and instructions, these demonstrations would not be implemented in a timely manner resulting in the potential loss of alternative and flexible benefits for beneficiaries. As a result, beneficiaries may not be provided health care choices that will produce the most beneficial health care outcomes. In addition, beneficiaries will be provided with an alternative health care choice that may alleviate the need for supplemental health care coverage resulting in more cost efficient health care.

We are requesting OMB review and approval of this collection within 10 business days from the date of this publication, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below within 9 days of this publication. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval:

Type of Information Collection Request: New collection.

Title of Information Collection: Medicare Waiver Demonstration Application.

Form No.: CMS–10069 (OMB# 0938–NEW).

Use: The Medicare Waiver Demonstration Application will be used to collect standard information needed to implement Congressionally mandated and administration high priority demonstrations. The application will be used to gather information about the characteristics of the applicant's organization, benefits and services they propose to offer, success in operating the model, and evidence that the model is likely to be successful in the Medicare program. The standard application will be used for all waiver demonstrations and will reduce the burden on applicants, provide for consistent and timely information collections across the demonstration, and provide a user-friendly format for respondents.

Frequency: On Occasion.

Affected Public: Business or other for profit and not for profit.

Number of Respondents: 75.

Total Annual Responses: 75.

Total Annual Hours: 1,600.

For convenience to the reader, we have attached a copy of the proposed standardized application and instructions to this notice for review and comment.

We have submitted a copy of this notice and related information collection package to OMB for its review of these information collections.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web site address at *http://www.hcfa.gov/regs/prdact95.htm,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and record keeping requirements must be mailed and/or faxed to the designees referenced below, within 9 days of the publication of this notice:

Centers for Medicare and Medicaid Services, Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Fax Number: (410) 786–0262, Attn: John Burke;

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167, Attn: Brenda Aguilar, CMS Desk Officer.

Authority: Section 412 of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 12, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

BILLING CODE 4120–01–P

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MEDICARE WAIVER DEMONSTRATION APPLICATION

DISCLOSURE STATEMENT According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

Medicare Waiver Demonstration Applicant Data Sheet	**Date Submitted**
Applicant Legal Name	**Date Received by CMS**
Address (city, county, state, zip code)	**Name, telephone number and address of person to be contacted on matters involving the application.**
Descriptive Title of Applicant's Project	**Project Duration** (MM/DD/YYYY) From _____ To _____
Proposed Project	**Type of Applicant** ☐ Academic Institution ☐ Individual ☐ Profit Organization ☐ Not for Profit Organization ☐ Other, please specify
Areas Affected by Project (cities, counties, states)	
Applicant's Medicare Provider Number(s)	**Applicant's Employer Identification Number**
Is The Applicant a Medicare Provider/Organization in Good Standing?	☐ Yes ☐ No If "No", attach an explanation.
TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMLY WITH THE TERMS AND CONDITIONS OF THE AWARD AND APPLICABLE FEDERAL REQUIREMENTS IF AWARDED.	
Type Name and Title of Authorized Representative	**Telephone Number**
Signature of Authorized Representative	**Date Signed**

This application provides an opportunity for eligible organizations to apply to participate in Medicare-waiver-only demonstrations sponsored by the Centers for Medicare & Medicaid Services (CMS).

CMS conducts Medicare-waiver-only demonstrations to test innovations that have been shown to be successful in the private sector in improving access and quality and/or lowering health care costs. These demonstrations may involve new benefits, fee-for-service or Medicare+Choice payment methodologies, and/or risk sharing that are not currently permitted under Medicare statute.

Section 402 of Pub. L. 92-603 grants CMS the authority to waive Medicare payment and benefit statutes to conduct these demonstrations. Demonstrations may also be initiated as a result of Congressional mandate.

BUDGET NEUTRALITY Medicare-waiver-only demonstrations must be budget neutral. Budget neutrality means that the expected costs under the demonstration cannot be more than the expected cost were the demonstration not to occur. Applicants must supply information and assumptions supporting budget neutrality that CMS will use in preparing a waiver package for submission to the President's Office of Management and Budget (OMB). OMB must approve Medicare waivers before implementing the demonstration.

DUE DATE Applications will be considered timely if we receive on or before the due date specified in the "DATES" section of the demonstration notice. Applications must be received by 5 P.M EST/EDT on the due date.

Only applications that are considered "timely" will be reviewed and considered by the technical review panel.

APPLICATION SUBMISSION An unbound original and 2 copies plus an electronic copy on diskette of the APPLICATION should be MAILED to the following address:

Department of Health and Human Services, Centers for Medicare & Medicaid Services, ATTN: Project Officer (Insert project officer name listed in demonstration announcement and name of demonstration)
Center for Beneficiary Choices, Division of Demonstration Programs, Mail Stop C4-17-27, 7500 Security Boulevard, Baltimore, Maryland, 21244

Applications must be typed for clarity and should not exceed 40 double-spaced pages, exclusive of the cover letter, executive summary, forms, and supporting documentation.

Because of staffing and resource limitations, and because we require an application containing an original signature, we cannot accept applications by facsimile (FAX) transmission.

FOR FURTHER INFORMATION
Please contact the project officer listed in the demonstration announcement and/or visit the CMS website at http://www.cms.hhs.gov/healthplans/research. Additional information about the demonstration, for example, fact sheets,

design reports, press releases, and question and answer documents will be periodically posted on the website. Be sure to check the website frequently if applying for a demonstration to be sure you have the most current information available.

APPLICATION CONTENTS OUTLINE To facilitate the review process, applications should be arranged in the following order:

1. Cover Letter
2. Medicare Waiver Demonstration Applicant Data Sheet
3. Executive Summary
4. Problem Statement
5. Demonstration Design
6. Organizational Structure & Capabilities
7. Performance Results
8. Payment Methodology & Budget Neutrality
9. Demonstration Implementation Plan
10. Supplemental Materials

CMS may provide start-up funds to cover implementation costs associated with the demonstration. If start-up funding is available, it will be announced in the demonstration solicitation. If requesting start-up funds, please include the Application for Federal Assistance Standard Form 424 after the Medicare Waiver Demonstration Applicant Data Sheet in the application and indicate the amount of funds requested in the cover letter.

APPLICATION REQUIREMENTS We will use all the information you submit in the application review process. Your application must include the following information.

Cover Letter Please be sure to identify the demonstration, indicate the target population and geographic location of the demonstration (for example, urban or rural), the CMS provider numbers assigned to the applicant, contact person, and contact information.

Medicare Waiver Demonstration Applicant Data Sheet Complete, sign, date, and return the Medicare Waiver Demonstration Applicant Data Sheet found at the beginning of this application.

Executive Summary Provide a 4 page summary of the key elements of the proposal (for example, Sections 3, 4, 5, 6, 7, 8, 9 under "Application Contents Outline").

Problem Statement Describe Medicare's current coverage and payment policy, and describe how or why changes to current policy would lead to reductions in Medicare expenditures or improvements in Medicare beneficiaries' access to and/or quality of care. Provide local examples. Describe the policy rationale for the proposal, who will benefit and why, and any previous experience with the proposed intervention.

Demonstration Design Describe the intervention including the scope of services covered and/or benefit design, and payment methodology including financial incentives and/or risk sharing arrangements. Indicate how eligible beneficiaries will be identified, targeted, and enrolled in the demonstration (if applicable).

If applicable, describe the study design. Identify the intervention and comparison

groups, and how Medicare beneficiaries will be assigned to each group. If a randomized study design is proposed, describe the process and provide a copy of the informed consent to be used.

Organizational Structure & Capabilities Describe your governance structure and management and clinical teams, and their success before implementing the proposed intervention. Provide an organizational chart that describes the functional and reporting lines of major departments and/or entities.

Demonstrate that infrastructure exists to implement and carry out the demonstration project. Provide copies of reports from clinical, financial, and management information systems and describe how they are used.

Provide copies of applicable Federal and State licenses. Indicate if the applicant is a Medicare provider in good standing. Describe any other applicable accreditation, credentialing, and/or certification processes and results.

Provide documentation of your organization's financial viability that will enable it to participate actively and successfully in the demonstration, for example, as a formal audit opinion from the past 3 years or the balance sheet from the past 3 years with a summary description. If there are any financial concerns, explain how your organization has addressed or will address these problems.

Performance Results Describe your systems and processes for monitoring clinical, financial, and operational performance. Identify key metrics collected and describe how you use this information to continuously improve the proposed intervention, correct deficiencies, satisfy beneficiaries, providers, and/or payers.

Payment Methodology & Budget Neutrality Please indicate the proposed payment amount and method. Proposed payments may be based on fee-for-service or Medicare+Choice rates, methodologies, or some combination, and may involve risk sharing.

Describe in detail any risk sharing arrangements. Provide a revenue and expense statement by year for the life of the demonstration.

Demonstrate that the proposed intervention is budget neutral. Provide expected, best, and worse case scenarios. Include all supporting cost effectiveness, evidence, and assumptions used for the calculations.

If start-up funds are available as indicated in the demonstration announcement, please indicate the amount requested and include in your budget neutrality calculations. Note, if requesting start-up funds, applicants must complete an "Application for Federal Assistance" Standard Form 424 that can be found on the CMS website at http://forms.psc.gov/forms/sf/sf.html and submit with this application.

Demonstration Implementation Plan Describe your implementation strategy, including tasks, resources, and timeline to implement the demonstration. Identify internal system and process modifications required to implement the demonstration. Describe your recruitment strategy and contingency plans for achieving beneficiary

thresholds. Identify the individuals and staff responsible for implementing the demonstration and attach biographies.

Supplemental Materials Include in this section copies of supporting materials requested or referenced throughout the application.

EVALUATION PROCESS We will convene technical review panels consisting of outside experts and our staff to review all of the applications. Panelists will receive a copy of the application along with a technical summary. Panelists will be asked to numerically rate and rank the application using evaluation criteria contained in the demonstration announcement.

Applicants should review the demonstration announcement for the specific evaluation criteria to be used by panelists to assess proposals, as well as additional information on the evaluation process and selection of awardees.

[FR Doc. 02–24443 Filed 9–26–02; 8:45 am]
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