

value for the dollars spent on health care.

The purpose of this demonstration is to test capitated payment arrangements with qualified organizations for the case management of specific diseases. The targeted populations include Medicare beneficiaries with chronic illnesses and special populations, such as dual eligibles and frail elderly. The payment models employed are intended to reduce costs and improve the coordination and quality of care for Medicare beneficiaries with select chronic diseases. In addition, the models may be applied to organizations that target dual eligibles or the frail elderly. Specifically, we will pay predetermined rates for each month for which an individual chooses to receive disease management services under this demonstration, according to a disease-specific risk adjustment approach currently being developed. (Disease specific risk adjusters are being developed as part of the model for M+C Risk adjustment. The legislative mandate for implementation of the risk adjustment model is January 1, 2004 for all plans. This risk adjuster, which will factor a greater number of comorbidities into the payment, is to be announced March 2003.)

There will also be a risk sharing option available (that is, a symmetrical risk sharing on profit and losses around a Medical-Loss-Ratio).

In exchange for the capitation amount, the applicant would be required to cover all Medicare-covered services for an individual participating in the demonstration, in addition to the disease management services. The applicant would be required to make such services available to beneficiaries participating in the demonstration, either directly or through arrangements with other Medicare-certified providers. Medicare beneficiaries participating in this demonstration would be informed that it is a condition of such participation that they receive services through the provider of disease management that has received a payment on behalf of the participant. For non-M+C organizations, only traditional Medicare fee-for-service (FFS) beneficiaries are eligible to participate in the demonstration. The intent of the demonstration is to attract traditional Medicare FFS beneficiaries, however, we will consider, on a case-by-case basis, allowing M+C organizations to market the demonstration to their current M+C beneficiaries and permit participation in the demonstration by one M+C beneficiary for every 2 traditional Medicare FFS beneficiaries they get to participate. Current M+C

beneficiaries would have to disenroll from their current M+C plan in order to participate in the demonstration. Organizations allowed to sign up current M+C beneficiary who disenrolled from an M+C plan to participate in the demonstration would have to agree to the monitoring of their Medical-Loss-Ratio (MLR).

The capitated payment method will require the collection and submission of simplified encounter data. The demonstration will use the Group Health Plan Payment System to pay the sites.

Under this demonstration, selected organizations would provide the clinical management of patients with high cost diagnoses such as stroke, congestive heart failure, and diabetes. (Applicants may propose a project that seeks to intervene with disease management services for Medicare eligible beneficiaries who have the potential for renal failure but who are not yet in dialysis. Randomization may be required for a proposal with this model.) The demonstration would be especially appropriate for provider sponsored organizations (PSOs), but is also open to other types of organizations such as disease management organizations, academic medical centers (AMCs) or M+C organizations. By targeting or encouraging the formation of integrated delivery systems and paying a single risk payment rather than reimbursing services on a fee-for-service basis, we hope to improve communication and coordination of services between patient, physician, disease management organizations, and other providers.

I. Background

A. Legislative Background

Section 402(a)(1)(A) of the Social Security Act Amendments of 1967 (Pub. L. 90-248), 42 U.S.C. 1395b-1(a)(1)(A), authorizes the Secretary to develop and engage in demonstrations "to determine whether, and if so which, changes in methods of payment or reimbursement * * * for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services. * * *

Under section 402(b) of the Social Security Act Amendments of 1967, the Secretary is authorized to waive requirements in title XVIII that relate to reimbursement and payment in order to carry out demonstrations authorized

under section 402(a) of the Social Security Act Amendments of 1967.

Under this demonstration, we would use the authority in section 402(b) to waive the "fee-for-service" (FFS) payment rules that would ordinarily apply to a beneficiary who has elected the "Original Medicare plan", and would substitute the methodology discussed in this notice, and agreed to in the demonstration contract.

B. Problem

Historically, a small proportion of Medicare beneficiaries has accounted for a major proportion of Medicare expenditures. For example, in 1996, 12.1 percent of all Medicare enrollees accounted for 75.5 percent (\$126.1 billion) of all Medicare FFS program payments. Many of these high-cost beneficiaries are chronically ill with certain common diagnoses, and most of the Medicare expenditures for their care are for repeated hospitalizations. During the next 30 years, as the population ages, the number of individuals and estimated cost of care for these individuals are expected to grow dramatically.

In addition, dual eligibles and special populations account for a large proportion of Medicaid and Medicare expenditures. The 1998 Medicare Chart Book reported that in 1995, the 6 million dually eligible beneficiaries accounted for 30 percent Medicare spending, though they only represented 16 percent of the Medicare population. Moreover, the dually eligible accounted for 35 percent of Medicaid spending, though they only made up 17 percent of the Medicaid population.

When services furnished to individuals with chronic illness are reimbursed on a FFS basis, health care has often been fragmented and poorly coordinated across multiple health care providers and multiple sites of care. Evidence-based practice guidelines have not always been followed, nor have patients always been taught how best to care for themselves. These shortcomings are particularly true for patients served under reimbursement systems in which providers lack incentives for controlling the frequency, mix, and intensity of services, and where they have limited accountability for the outcomes of care.

Many M+C organizations and private insurers have realized the importance of effectively coordinating the care of services for persons with select chronic conditions. The quality of care, as well as the cost of care, can be improved through better integration of the delivery system. In order to create incentives to maintain costs, encourage the coordination of services, and