

additional information about these demonstrations.

We are currently conducting other demonstrations that test either case or disease management. In one demonstration, Lovelace Health Systems in Albuquerque, New Mexico was chosen to operate demonstrations of intensive case management services for high-risk patients with congestive heart failure and diabetes to improve the clinical outcomes, quality of life, and satisfaction with services. The other is a larger scale demonstration involving 15 sites authorized by the Balanced Budget Act (BBA) of 1997 (Pub. L. 105-33, enacted on August 5, 1997) to evaluate methods such as case management and disease management that improve the quality of care for beneficiaries with a chronic illness. The coordinated care demonstration was designed based on the findings of a review of best practices for coordinating care in the private sector. More information about the Coordinated Care Demonstration can be found on our Web site www.cms.hhs.gov/healthplans/research/coorcare.asp.

E. The Capitated Disease Management Demonstration

This demonstration will provide clinical management of—

(1) Patients with high cost diagnoses such as stroke, congestive heart failure, and diabetes, (2) people who receive both Medicare and Medicaid, or (3) frail elderly patients that would benefit from a greater coordination of services. The project will allow us to build on the experiences of existing clinical disease management organizations. The delivery system will be targeted to PSOs but is open to other types of organizations such as disease management organizations, AMCs, or M+C organizations. Participation by qualified beneficiaries currently in the traditional fee-for-service Medicare program is the intended objective, however, we will consider allowing M+C organizations, on a case-by-case basis, to accept one M+C beneficiary for participation in the demonstration for every 2 traditional Medicare FFS beneficiaries that participate. Organizations allowed to accept a current M+C beneficiary (who must actively disenroll in the plan first) must allow the monitoring of their Medical-Loss-Ratio (MLR).

In developing this demonstration, we reviewed the work and recommendations of organizations such as the NDMA and NCQA, and examined our prior and current experience with similar demonstrations.

This demonstration differs from its predecessors in that the focus is on

paying a risk adjusted capitated rate with negotiated risk sharing arrangements to qualified organizations in order to create incentives to improve the quality and coordination of care. Moreover, we will be using the recently developed risk-adjustment payment methodology that will apply to all M+C organizations beginning in 2004. It is a selected significant disease model, which includes many chronic illnesses that are relevant to predicting future expenditures.

For the purpose of this demonstration, disease management is defined as a systematic approach to managing health care that aims to improve patient care, physician treatment practices, communication and coordination, and access to needed services, and incorporates the following features:

Eligible Population

Beneficiary participation in this demonstration is strictly voluntary. Each beneficiary must be fully informed about the demonstration and must sign an informed consent form in order to participate. In addition to indicating informed consent, Medicare beneficiaries must satisfy the following conditions in order to be able to participate in the demonstration project:

Eligibility Criteria

- Must be a Medicare beneficiary enrolled in Part A and Part B.
- Medicare must be primary payer.
- Must have a chronic disease, such as stroke, congestive heart failure, or diabetes (except for dual eligible or frail elderly).

Medicare beneficiaries will be excluded from eligibility if they:

- Are currently enrolled in a M+C plan; however, we will consider allowing M+C organizations to allow participation in the demonstration by one M+C beneficiary for every 2 traditional Medicare FFS beneficiaries.
- Are receiving hospice or end stage renal disease benefits.
- Are currently participating in another CMS demonstration.
- Are unable to participate in self-care activities due to severe dementia or other serious mental illness.

Payment

A contracting provider or provider organization will be paid for the services it provides to demonstration participants (without regard to the frequency and intensity of the services received by a given individual) on a monthly capitation basis. In exchange for this payment, the contractor would be responsible for furnishing or arranging for all covered Medicare Part

A and Part B services. A listing of the beneficiaries who have elected to receive disease management services through the demonstration will be furnished to us on a monthly basis, which will be submitted to the Group Health Payment System to process payments for the services furnished to these beneficiaries.

The capitated payment rate will be based on the higher of the rate paid under the M+C program or 99 percent of a county-level fee-for-service base rate that will be calculated using a method developed by our Office of the Actuary. The payment rate will be fully risk adjusted using the new risk-adjustment methodology.

In compliance with the legislative mandate in BIPA, we have announced a draft risk adjustment model that includes inpatient and ambulatory diagnosis data, which will be implemented in January 1, 2004. The specific payment methodology will be announced in March 2003. We have chosen a selected significant disease model with approximately 61 condition groups. This model incorporates multiple chronic diseases into the payment system. Although the new risk adjustment payment methodology will not be implemented for the M+C program until January 2004, demonstration payment amounts will be calculated using the new risk-adjustment payment methodology, and will be fully risk adjusted, rather than being phased-in as is the case in the M+C program. (M+C organization payments are subject to the congressionally mandated phase-in of risk adjustment whereby only a portion of the payment is risk adjusted and the other portion of the payment is calculated using demographic factors. Under this demonstration, the payment amount will be fully risk adjusted.)

The following example is for applicants to estimate risk scores based on the current model of the selected significant condition model. This example is for illustrative purposes only.

Our example is a female, age 76, and she is Medicaid eligible. She has the following conditions:

- Chronic obstructive pulmonary disease (COPD).
- Congestive heart failure (CHF).

Go to illustrative table found at www.cms.hhs.gov/healthplans/encounter/RAModels.pdf for determining estimated payments. Use the draft coefficient under the “61-condition” model column to find estimates.

Payment estimate = Female, age 76 (\$2,500) + Medicaid (\$1,000) + COPD