2003 Edition

Active Projects Report

Research and Demonstrations in Health Care Financing

Contents

1 Theme 1: Monitoring and Evaluating CMS Programs

11 Theme 2: Improving Managed Care Payment and Delivery

23 Theme 3: Improving Fee-for-Service Payment and Delivery

47 Theme 4: Future Trends Influencing Our Programs

51 Theme 5: Strengthening Medicaid, State Children's Health Insurance Program (SCHIP), and State Programs

99 Theme 6: Meeting the Needs of Vulnerable Populations

107 Theme 7: Outcomes, Quality and Performance

123 Theme 8: Building Research Capacity

157 Mandate and Authority

173 Indices:
- *Topical Index*
- *Alphabetical Index of Research and Demonstration Projects*
- *Awardee Organizations*
- *Principal Investigators*
- *State Index of Research and Demonstration Projects*
- *CMS Project Officers and Project Directors*
- *Facts About the Centers for Medicare & Medicaid Services*

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Centers for Medicare & Medicaid Services

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Active Projects Report

Research and Demonstrations in Health Care Financing

2003 Edition

Centers for Medicare & Medicaid Services

FOREWORD

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare program and programs administered by States such as Medicaid and the State Children's Health Insurance Program (SCHIP). CMS oversees insurance regulation, the survey and certification of health care facilities, and the Clinical Laboratory Improvements Amendments. We serve one in four seniors, children, people with end stage renal disease, and people with disabilities. We also provide beneficiaries with information about our programs, Medigap options, consumer research, and grievance and appeals processes.

CMS directs roughly 600 individual research, demonstration, and evaluation projects. Our research helps us 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 affects 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.

One of the Agency's challenges is to develop and implement new health care payment approaches and financing policies and to evaluate the impact of our programs. Another is how to modernize Medicare from a medical acute care model to a comprehensive health care model that encourages healthy aging. CMS strives to meet the challenges of short-term health policy needs with a long-term perspective to provide meaningful information and analyses responsive to the needs of our programs and customers. CMS, together with States, contractors, grantees, and other Federal agencies, is committed to research and demonstrations aimed at improving our programs, ensuring the quality of care and providing modern health care services.

Congress created Medicare and Medicaid in 1965. Medicare originally provided health care coverage to Americans over the age of 65. In 1972, the program was expanded to Americans living with disabilities and people with end stage renal disease. Medicaid is a joint Federal-State program that provides health care coverage to the aged, blind, people with disabilities, and low-income families with children under 21.

CMS research both anticipates the future of our programs, and reflects the Agency's legislative and operational responsibilities. More recent legislation includes:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided for improved continuity or "portability" of group health plan coverage and for group health insurance provided through employment or through the individual insurance market. CMS regulates the small and individual private health insurance markets and national administrative simplification standards for all electronic health care transactions.

- The Balanced Budget Act of 1997 (BBA) established Medicare+Choice as Part C of the Medicare program, creating an array of new managed care and other health plan choices for beneficiaries, in addition to a coordinated open enrollment process.

- The BBA also created the State Children's Health Insurance Program (SCHIP) which is designed to assist those working families with incomes too high for Medicaid but too low to be able to afford private health insurance.

- The Balanced Budget Refinement Act of 1999 made numerous changes to the Medicare program aimed at reducing the impact of the payment reductions to providers in the BBA, stabilized the SCHIP allotment formula and modified the Medicaid Disportionate Share Hospital program.

- The Ticket to Work and Work Incentives Improvement Act of 1999 expanded the availability of Medicare and Medicaid for certain beneficiaries with disabilities who return to work. The New Freedom Initiative announced by President Bush on February 1, 2001 is part of a nationwide effort to remove barriers to community living for people with disabilities.

- In 2000, the Benefits Improvement and Protection Act made numerous changes to the Medicare, Medicaid and SCHIP programs.

The Office of Research, Development, and Information prepares the annual *Active Projects Report: Research and Demonstrations in Health Care Financing* to inform CMS customers of our research. It inventories both intramural projects conducted by CMS staff and extramural projects conducted by contractors, grantees, and other awardees with CMS support. While most of the extramural projects are funded from CMS' research, demonstration, and evaluation budget, some of the quality-related studies conducted by Quality Improvement (formerly Peer Review) Organizations are supported by other CMS budgets.

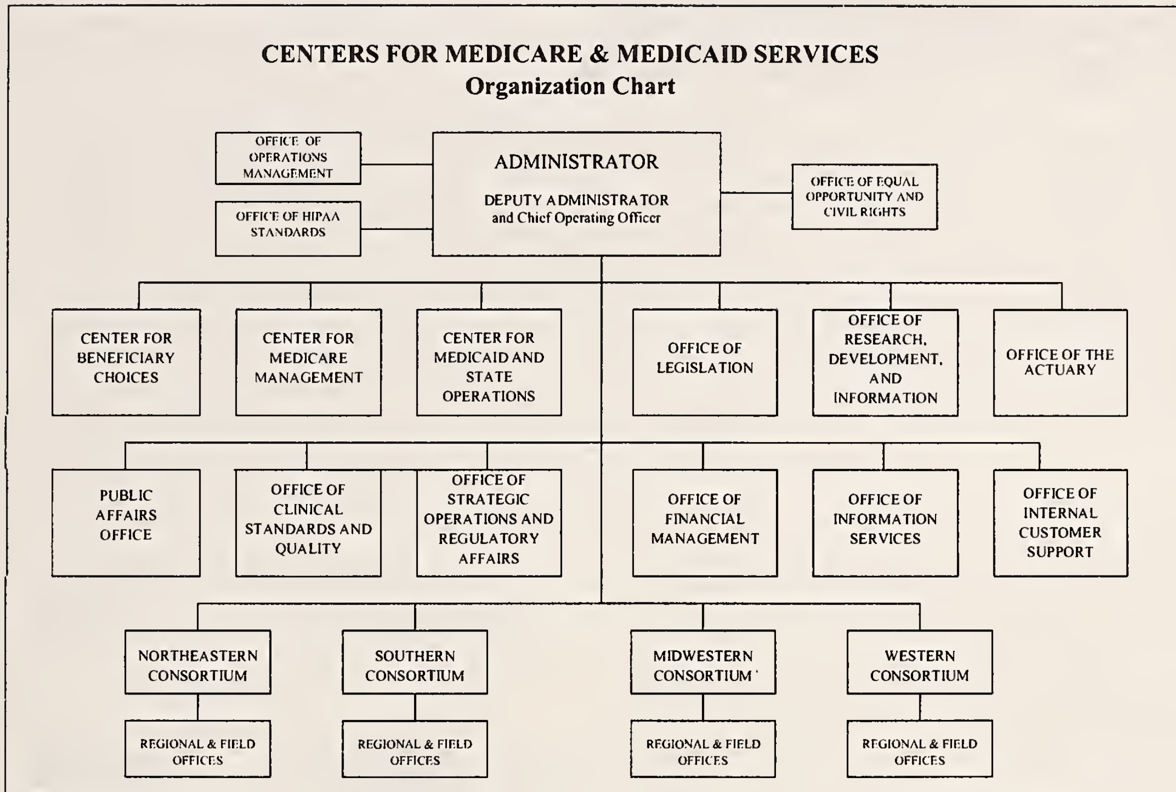
The 2003 edition of the *Active Projects Report* provides basic information on CMS research, demonstration and evaluation projects active from January 1 through December 31, 2002. It is organized by theme:

Theme 1: Monitoring and Evaluating CMS Programs;
Theme 2: Improving Managed Care Payment and Delivery;
Theme 3: Improving Fee-For-Service Payment and Delivery;
Theme 4: Future Trends Influencing Our Programs;
Theme 5: Strengthening Medicaid, State Children's Health Insurance Program (SCHIP), and State Programs;
Theme 6: Meeting the Needs of Vulnerable Populations;
Theme 7: Outcomes, Quality and Performance; and
Theme 8: Building Research Capacity.

The Active Projects Report presents a brief description of each project and its status as of December 31, 2002. The abstracts provide an identification number, the project title, the CMS project officer name, the awardee, funding, and the period of performance. Several indices are provided at the back of this book to help readers locate information regarding specific projects - organized by project title, project officer, principal investigator, awardee organization, State and legislative mandate summary. More detailed information regarding specific projects may be obtained from CMS project officers directly.

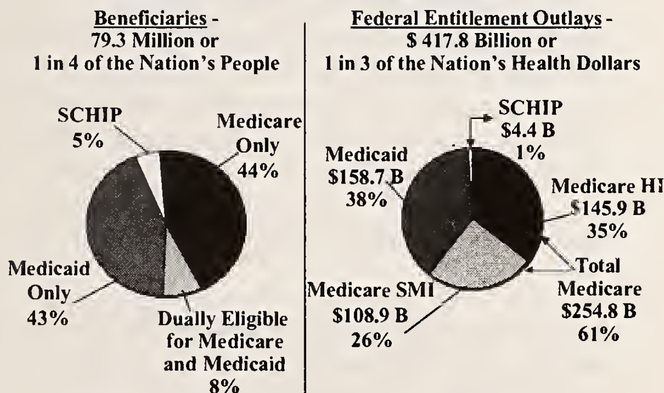
This is the twenty-third edition of *The Active Projects Report.* For more information, please visit the CMS website at www.cms.hhs.gov.

Stuart Guterman
Director
Office of Research, Development, and Information


CENTERS FOR MEDICARE & MEDICAID SERVICES
Organization Chart
OFFICE OF OPERATIONS MANAGEMENT
OFFICE OF HIPAA STANDARDS
ADMINISTRATOR
DEPUTY ADMINISTRATOR and Chief Operating Officer
OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
CENTER FOR BENEFICIARY CHOICES
CENTER FOR MEDICARE MANAGEMENT
CENTER FOR MEDICAID AND STATE OPERATIONS
OFFICE OF LEGISLATION
OFFICE OF RESEARCH, DEVELOPMENT, AND INFORMATION
OFFICE OF THE ACTUARY
PUBLIC AFFAIRS OFFICE
OFFICE OF CLINICAL STANDARDS AND QUALITY
OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL MANAGEMENT
OFFICE OF INFORMATION SERVICES
OFFICE OF INTERNAL CUSTOMER SUPPORT
NORTHEASTERN CONSORTIUM
SOUTHERN CONSORTIUM
MIDWESTERN CONSORTIUM
WESTERN CONSORTIUM
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES

Theme 1: Monitoring and Evaluating CMS Programs

As the United States health care system continues to change, there is an ongoing need to monitor and evaluate the performance of the programs CMS administers. Beyond traditional measures of performance, like cost containment, quality, health outcomes, and access to care, we attempt to measure various beneficiary-focused attributes, such as knowledge of health behaviors. In our monitoring, we track how well Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) meet the needs of specific groups of beneficiaries, including vulnerable populations. Our research also examines more specific policy issues. For example, as Medicare and Medicaid continue to pursue managed care options, we examine the cost-effectiveness and quality of managed care, as well as beneficiary satisfaction. CMS monitors and evaluates the impact of Medicaid, welfare reform, SCHIP, and our beneficiary information program on beneficiaries. CMS is committed to evaluating our programs to gain new insights into how they can perform better. These insights inform our regulatory, administrative, and legislative policymaking.



Source: FY 2003 President's Budget.

01-114 Evaluation of Balanced Budget Amendment (BBA) Impacts on Medicare Delivery and Utilization of Inpatient and Outpatient Rehabilitation Therapy Services

Project Officer: Philip Cotterill
Period: September 2001–December 2004
Awardee: Health Economics Research
Funding: $998,540

Description: This project studies the impact of the Balanced Budget Act of 1997 (BBA) on the delivery and utilization of inpatient and outpatient rehabilitation therapy services to Medicare beneficiaries. Many of the BBA changes, some already implemented and others still under development, directly affect payment for rehabilitation therapy services. These policies include per beneficiary therapy limits applicable to certain outpatient settings, skilled nursing facility prospective payment system, home health agency prospective payment system, inpatient rehabilitation facility prospective payment system, long term care hospital prospective payment system, and outpatient therapy prospective payment system. This project will study the period 2000-2003, and will study changes in beneficiary access and utilization of therapy services across all these settings with special attention to changes in one or more settings that follow a payment change in another setting.

Status: This is a continuation and extension of previous work, "Medicare Post-Acute Care: Evaluation of BBA Payment Policies and Related Changes" (contract 500-96-0006/04), which covered the period 1996-1999.

02-079 Design and Implementation of a Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries

Project Officer: Renee Mentnech
Period: September 2002–September 2003
Awardee: Mathematica Policy Research, (DC)
Funding: $0

CMS Centers for Medicare & Medicaid Services

Description: The purpose of this project is to design and implement a targeted, short, beneficiary survey on access to physician services among Medicare beneficiaries. The intent of this targeted survey is to enhance the ability of CMS to determine, on as close to a real time basis as possible, whether Medicare beneficiaries are experiencing access problems in specific geographic areas.

01-144 Evaluation of Private Fee-for-Service Plans in the Medicare+Choice Program

Project Officer: Nancy Zhang
Period: September 2001–September 2004
Awardee: Abt Associates
Funding: $1,407,867

Description: The purpose of this project is to evaluate the new private fee-for-service (PFFS) option available under the Medicare+Choice (M+C) program. The evaluation will use a combination of primary and secondary data sources to evaluate the effects of the option on beneficiaries and program costs. Primary data will be collected through site visits to participating plans and beneficiary surveys. The PFFS plan option is one of the new types of organizations provided for under the M+C provisions. The project involves the Sterling Plan, which has been available to beneficiaries since July, 2000 and captures many beneficiaries who were previously enrolled in an M+C plan that withdrew from the program and for whom this plan is the only M+C option available. Analytic issues to be addressed in the evaluation can be grouped into three broad categories: 1) beneficiary analyses (enrollment, beneficiary experiences with the plan, utilization); 2) Medicare program impacts (payment); and 3) plan and provider impacts (market, program administration, participation).

Status: This newly initiated project is in the startup phase.

01-116 Evaluation of the Impact on Beneficiaries of the Medicare+Choice Lock-in Provision

Project Officer: Mary Kapp
Period: September 2001–September 2004
Awardee: Barents Group
Funding: $380,298

Description: This project will explore the impact on Medicare beneficiaries of the lock-in provision of the Balanced Budget Act of 1997 (BBA). The lock-in provision places limits on the frequency, timing and circumstances under which Medicare+Choice (M+C) enrollment elections can be made. These changes are phased in over a 2-year period beginning January 1, 2002. The purpose of this project is to: 1) examine the current (pre-lock-in) patterns of enrollment and disenrollment in M+C using existing CMS administrative data; 2) design a methodology to quantify the impact on Medicare beneficiaries of the lock-in provision; and 3) analyze the impact on beneficiaries of the first year of the lock-in provision.

Status: The project is in its developmental stage.

00-052 Evaluation of the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs

Project Officer: Noemi Rudolph
Period: September 1999–November 2002
Awardee: Health Economics Research
Funding: $1,466,933

Description: This project is designed to evaluate quantitatively and qualitatively the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs in the following areas: 1) the motivations and perceptions of enrollees and nonenrollees, 2) reasons for State variation in enrollment patterns, 3) the impact of enrollment on Medicare and Medicaid costs and service use, and 4) the impact of enrollment on out-of-pocket costs of eligible individuals. Primary data collection activities will include: a survey of a national sample of QMB and SLMB enrollees and of eligible

non-enrollees, focus groups of enrollees and non-enrollees, a survey of State agencies, and case study interviews with officials from agencies and advocacy groups. Secondary data sources include: the Medicare Current Beneficiary Survey, the Medicare National Claims History file, the Medicaid Statistical Information System, Third Party Buy-In file, and the Medicare Enrollment Database. Descriptive and multivariate analyses will be conducted with the primary and secondary data.

Status: In September 2000, this project was modified to include case-study evaluations of State programs under the Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles grants. The period of performance for the evaluation project was also extended from September 2002 to December 2002 to cover the period of the grants. In early 2001, this project was modified to include a study on limitation on State payment for Medicare cost-sharing affecting access to services for Qualified Medicare Beneficiaries.

99-069 Evaluation of the State Child Health Insurance Program

Project Officer: Rosemarie Hakim
Period: July 1999–July 2004
Awardee: Mathematica Policy Research, (DC)
Funding: $4,256,094

Description: This project evaluates the State Children's Health Insurance Program (SCHIP). It examines and tracks the impact of SCHIP in reducing the numbers of low-income uninsured children. States are required to report and assess the operation of their children's health insurance programs. This project involves a summary and analysis of the State evaluations and an analysis of external SCHIP-related activities (meta-analysis). It will also analyze the effect of SCHIP on enrollment expenditures and use of services in Medicaid and State health programs and evaluate stand-alone and Medicaid expansion programs, including the effectiveness of their outreach activities, and the quality of care.

Status: Evaluation is in its third year. The SCHIP Report to Congress was submitted. Current work involves case studies of eight States as well as continuing monitoring and evaluating the effect of SCHIP in 50 States, the Territories, and the District of Columbia.

98-224 Home & Community-based Services Study

Project Officer: Susan Radke
Period: September 1998–March 2003
Awardee: Lewin Group
Funding: $2,308,371

Description: The purpose of this project is to design and implement a study of the impact of Medicaid home and community-based service (HCBS) programs on quality of life, quality of care, utilization, and cost. The scope of the study includes both Medicaid home and community-based service waiver programs as well as other Medicaid-funded long-term care services. The research project will study the Medicaid financing and delivery of services to older and younger people with disabilities in six States, and the Medicaid financing and delivery of services for individuals with mental retardation and developmental disabilities in six other States. One goal of the research is to assist Federal and State policy makers in gaining further knowledge about: 1) how Medicaid HCBS program funds are currently used; 2) how policies affect costs, access to care, and quality of services; and 3) key program design features that are helpful to achieving cost-effective use of program services.

Status: The 12 State site visits in phase one of the study are approved. Phase two is currently in progress. The Office of Management and Budget (OMB) approved the Medicaid recipient survey, which was fielded late December 2001 to early January 2002.

00-124 Medicaid Prescription Drug Data

Project Officer: David Baugh
Period: September 2000–August 2002
Awardee: CHD Research Associates
Funding: $74,971

Description: This project supports intramural research by preparing tabulated data using State Medicaid Research File data from 1996, 1997, and 1998. Based on earlier findings, this work examines the mix of prescription drugs that are being provided to Medicaid enrollees. The intramural project profiles use and expenditure by eligibility group based on prescription drug mix. It also identifies which drug categories are most utilized and which are the most expensive. A cross-sectional design is being used. Approximately five to seven States will be individually viewed and subsequently compared.

Status: Specifications for creating a prototype of the tabulated data have been created and work is underway.

01-210 Home Health Data Link

Project Officer: Ann Meadow
Period: September 2001–September 2002
Awardee: Fu Associates
Funding: $300,000

Description: This task is developing a working home health data management linking system with capabilities to link data from the Outcome and Assessment Information Set (OASIS) repository with patient level data from a variety of CMS data files. The Data Link will be made available to all CMS components and their contractors to meet individual data extract needs. This Data Link will create a multipurpose home health-linked file to supply the most frequently needed data extracts in a cost-efficient manner. The multipurpose home health-linked file will be comprised of the most utilized/requested/needed merged home health-related data. This file will include episode-level information from the national OASIS repository which has been linked with inpatient, outpatient, physician, and home health claims data; skilled nursing home data from the Minimal Data Set (MDS); and data from the Online Survey Certification and Reporting System/Quality Improvement Evaluation System (OSCAR/QIES).

Status: This newly initiated project is in the startup phase.

00-068 Activities Prior to the Construction of State Medicaid Research Files (SMRFs) for 1996-1998

Project Officer: David Baugh
Period: September 2000–August 2002
Awardee: Mathematica Policy Research, (DC)
Funding: $441,771

Description: This project supports Medicaid eligibility and services claims experts collecting missing information in the Medicaid Statistical Information System (MSIS) files. Code maps and crosswalks are developed to incorporate essential information into CMS' State Medicaid Research File (SMRF) data. The purpose of this project is to increase the validity and consistency of SMRF data and improve the usefulness of these data for policy analysis and research, in particular for the evaluation of the impact of Welfare Reform on Medicaid. The SMRF database and file layouts were developed in 1992 and 1993. Data from the Medicaid Statistical Information System (MSIS) files for each participating State were then converted into SMRF data. This project will: 1) map eligibility codes into standard SMRF codes, 2) revise claims adjustment scenarios to create final action events (e.g. stays and visits), 3) map type of service codes into standard SMRF codes, 4) prepare a delivery indicator to mark the person-summary record of each woman who delivered, 5) create SMRF outpatient and prescription drug files, 6) add other data elements to SMRF, 7) link SMRF eligibility data to the Medicare Enrollment Data Base, and 8) conduct validation activities for the SMRF data.

Status: Work is nearly complete for 1996 to 1998 SMRF data files. The project was modified to support continued development of the 1999 data. For 1999 and later years, the data has a new name, the Medicaid Analytic eXtract (MAX).

00-066 Design and Test of Evidence-Based Communications Strategies to Increase Consumer Awareness and Understanding of Long-Term Care Options

Project Officer: Ted Chiappelli
Period: September 2000–March 2003
Awardee: MEDSTAT Group (DC)
Funding: $7,095,615

Description: The objective of this program will be to provide Medicare beneficiaries with information about their long-term care options, information on Medicaid long-term care policy, service delivery options and how to access information and assistance. This project will 1) document what is known about consumer understanding of long-term care issues in order to help beneficiaries with awareness of and how to provide useful and understandable information, 2) pilot test a variety of culturally competent, community-based communication and assessment activities related to long-term care planning and treatment options, 3) have ongoing evidence-based assessments of pilot activities, and 4) have ongoing reporting on the formative research and assessments.

Status: The contractor is preparing to launch the campaigns in the sites. They are at the halfway point, having completed all formative research including the environmental scans and testing. There will be four sites: Fresno, Delaware, West Palm Beach, and Milwaukee. Precampaign surveys to establish baseline information are underway in all four sites. The evidence-based communications activities will be conducted January-October 2002. This will be followed by post-campaign evaluation surveys and process measures. Analysis pursuant to delivery of evidence-based national strategy is due in March of 2003.

01-115 Assessment of Medicare & You Education Program

Project Officer: Lori Teichman
Period: September 2001–April 2004
Awardee: Barents Group
Funding: $1,777,640

Description: This project assesses how well CMS is communicating with Medicare beneficiaries, caregivers and partners. As part of the National Medicare Education Program (NMEP), CMS provides information to beneficiaries about the Medicare program and their Medicare+Choice options. The NMEP employs numerous communication vehicles to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities, and protections; and health behaviors. The goal of NMEP is to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the Federal government and its private sector partners) as trusted and credible sources of information.

Status: Work began in September 2001. The Medicare&You Regional Survey will be fielded in January 2002 through April 2002. The New Enrollee Survey is scheduled to start in late April 2002. The mystery shopping tasks (SHIPS and 1-800-MEDICARE) were pilot tested in December 2001. Site visits (data collection) for the partners' assessment, the needs/gaps assessment and the return on investment assessment is underway. Data are being processed on an ongoing basis for the audience feedback forms and the Medicare&You handbook postcards.

99-031 Telephone Customer Service Strategy–Customer Satisfaction

Project Officer: Lori Teichman
Period: May 1999–March 2002
Awardee: Lewin Group
Funding: $1,767,167

Description: This project provides assistance in developing and implementing a nationwide survey of customer satisfaction with telephone service provided by CMS' Medicare contractors. It will provide technical guidance and support in the development and implementation of a customer satisfaction methodology and put in place processes that will yield specific and standardized measures of customer satisfaction. The project focuses on the extent to which

the caller is satisfied with the services provided, including the professionalism and courtesy of the customer services representatives, ease of use of the telephone system, and overall quality of service.

Status: A recommendation was developed on the feasibility of an independent beneficiary satisfaction survey for call centers. The survey was developed, piloted and implemented by telephone. Finally, a conference was developed and held on telephone customer service.

99-028 Expanded Evaluation of Medicare & You Handbook: 2000

Project Officer: Sherry Terrell
Period: March 1999–June 2002
Awardee: Research Triangle Institute, (NC)
Funding: $1,086,060

Description: The purpose of this project was to establish national measures of Medicare beneficiaries' knowledge of the basic Medicare program and their understanding of new Medicare+Choice options available under the Balanced Budget Act of 1997. The objectives of the project supported and provided feedback for monitoring and continuous quality improvement of National Medicare Education Program (NMEP) informational materials directed to the Medicare population. To achieve these objectives, the study evaluated the NMEP's Medicare&You Handbook: 2000 and selected information distribution channels such as the 1-800-MEDICARE toll free telephone line using a beneficiary program knowledge index. Additionally the effects of payments incentives to complete questionnaires and single mailing versus repeated mailings were tested.

Status: This project has been completed. The financial incentive payment experiment was found to have a significant effect on beneficiary response to the survey at each stage of data collection, ranging from 18.2 percentage to 8.3-percentage point differences. Repeated exposure to the handbook increased awareness. The multivariate analyses found the effect of receiving and reading the handbook on beneficiary program knowledge was modest but significant. Overall, beneficiaries who read the handbook demonstrated 12 percentage points higher knowledge scores about the Medicare program than those who did not receive the handbook or those who received but did not read it. The Medicare&You Handbook: 2000 has been successful in achieving multiple NMEP goals. The following reports are available from the National Technical Information Service, "Focus Group Results from the National Evaluation of Medicare and You 2000 Handbook: Beneficiaries (February 15, 2001)," Accession Number PB2001-103722, "Focus Group Results from the National Evaluation of Medicare and You 2000 Handbook: Non-Beneficiary Helpers (February 15, 2001)," Accession Number PB2001-103723.

98-255 Performance Assessment of Web Sites

Project Officer: Barbara Crawley
Period: August 1998–April 2003
Awardee: Barents Group
Funding: $1,317,513

Description: This project is: a) evaluating; b) setting up an ongoing system for feedback from consumers and c) making recommendations for future changes to the consumer oriented Web site www.medicare.gov. The Web site was established by CMS to service Medicare beneficiaries and their caregivers. Other potential users of the site include researchers and advocacy groups.

Status: Several of the strategies used to assess the website have ended. While the bounce-back form on the website has been temporarily removed, data from the bounce-back survey and the other assessment strategies, including focus groups and expert reviews, are being compiled. Work is continuing to improve and update the website using the data gathered from the multi-faceted assessment.

96-080 HCFA On-Line: Market Research for Beneficiaries–I

Project Officer: Julie Franklin
Period: April 1996–December 2003
Awardee: Barents Group
Funding: $6,344,124

Description: CMS implemented a market research program to provide ongoing assessment of the information needs of our beneficiaries. It examined what information beneficiaries want and need and how such information can best be communicated to them. The Agency placed special emphasis on understanding the requirements of subgroups who may have special communication needs (e.g., vision-impaired or non-English-speaking beneficiaries). The project consisted of multiple phases, including conducting inventories of existing information on communication strategies relevant for beneficiaries, conducting focus groups to explore the information needs of beneficiaries, and collecting and analyzing survey data on information needs in beneficiary populations. This research will be used to help guide the development of CMS' communication strategy.

Status: A large series of focus groups have been conducted with the general population of Medicare beneficiaries including a number with special groups. An inventory of groups that work with beneficiaries is complete and includes information from approximately 170 organizations. Examples of such groups are advocacy organizations, social service providers, health care providers, government agencies, and Medicare carrier and other insurance organizations. In addition, a special supplement to the Medicare Current Beneficiary Survey was used to collect information on the information needs and preferences of beneficiaries.

99-063 HCFA On-Line: Market Research for Beneficiaries–II

Project Officer: Julie Franklin
Period: September 1999–December 2003
Awardee: Barents Group
Funding: $14,367,373

Description: This project serves as a vehicle to conduct a variety of social marketing research with Medicare beneficiaries. The project is committed to carrying out targeted projects that document consumer reality through consumer research. Topics of the research are generally focused around communicating program benefits, appeal rights, health plan and provider choices, and treatment options to people with Medicare. Specific work has been done on existing Medicare publications, regulations, policies, developing message strategies and communication plans, monitoring desired behaviors, and evaluating the process.

Status: This is an extension of the work begun under 500-95-0057/02. This contract continues to conduct social marketing research on specifically identified initiatives that involve communication with Medicare beneficiaries.

06-173 Beneficiary Knowledge: Questionnaire Item Development and Cognitive Testing Using Item Response Theory

Project Officer: Sherry Terrell
Period: May 2001–May 2004
Awardee: Research Triangle Institute, (NC)
Funding: $268,853

Description: This project evaluates the effectiveness of the National Medicare Education Program (NMEP), CMS' primary information and education program. The evaluation focuses on the objectives of the NMEP: to 1) provide beneficiary access to information, 2) raise beneficiary awareness that information is available, 3) heighten awareness of some basic Medicare+Choice messages, and, 4) communicate information useful for making informed health services decisions. A substantial pool of Medicare beneficiary knowledge questions and tests cognitive reliability and validity of the items, assuring a consistent Medicare knowledge index over time. The content categories cover both core knowledge areas that generally remain consistent from year to year, as well as supplemental topics that may change more frequently. Medicare beneficiary knowledge data collected through the Medicare Current Beneficiary Survey (MCBS) will constitute the starting pool of questionnaire items. Item Response Theory (IRT) methodology is used to evaluate measures of knowledge and validate items in the MCBS knowledge index.

Status: This contract was modified to extend the period of performance through May 2004.

99-080 Implementation of Consumer Assessments of Health Plans Disenrollment Survey

Project Officer: Christine Smith-Ritter
Period: September 1999–November 2002
Awardee: University of Wisconsin - Madison
Funding: $4,458,022

Description: This project implements the Medicare managed care version of the Consumer Assessments of Health Plans (CAHPS) Disenrollment Survey. This is a survey of a sample of Medicare beneficiaries who have disenrolled from each Medicare+Choice contracting health plan eligible for inclusion in the study sample. CMS sponsored the development of a disenrollment version of the CAHPS survey (the Medicare CAHPS Disenrollment Survey), a Medicare fee-for-service version of CAHPS, and formats for reporting survey results that are easy for beneficiaries to understand in order to encourage beneficiary use of quality information. All three surveys include comparably worded questions on such topics as coordination of care, referrals to specialists, ease of obtaining needed care, patient/physician interaction, relations with office staff, customer service, and ease of obtaining specialty services and equipment.

Status: Multivariate analysis to group the reasons for reporting has been completed and additional subgroup and casemix analysis is underway. Annual health plan reports, interim 2001 reports, and consumer reporting of 2000 disenrollment rates and results have been mailed out or made public. The CAHPS effort is a 5-year cooperative agreement between the Federal agencies and three grantees, headed by the Agency for Healthcare Research and Quality.

97-265 Implementation of the Medicare Consumer Assessment of Health Plans Survey

Project Officer: Amy Heller
Period: September 1997–September 2002
Awardee: Barents Group
Funding: $25,592,481

Description: This project implements the Medicare version of the Consumer Assessments of Health Plans survey (CAHPS) in all Medicare risk and cost managed care plans. The primary purpose of the survey is to collect, analyze, and disseminate information to Medicare beneficiaries to help them choose among plans. It will also be used with other available data to monitor and evaluate the quality of care and relative performance of managed care plans, and to compare the satisfaction of beneficiaries in the managed care and fee-for-service systems. It is a nationwide satisfaction survey of Medicare beneficiaries, currently enrolled and recently disenrolled, from their managed care plans which proportionately samples a cross-section of Medicare managed care enrollees stratified by plan to assess their level of satisfaction with access, quality of care, plans' customer service, resolution of complaints, and their utilization experience.

Status: The survey completed its 5th year of data collection at the end of December. The unadjusted response rate is 82 percent with 127,654 surveys returned by mail and 28,042 surveys completed by telephone. For the past three years, the survey has achieved a response rate greater than 80 percent. Since this is an ongoing effort, the survey was rebid in early spring of 2002.

00-043 National Implementation of Medicare Consumer Assessment of Health Plans Study - Fee-for-Service (CAHPS-FFS) Survey

Project Officer: Edward Sekscenski
Period: August 2000–August 2002
Awardee: University of Wisconsin - Madison
Funding: $7,378,706

Description: This project implements the Medicare Consumer Assessments of Health Plans Fee-For-Service (CAHPS-FFS) survey. Since 1998, CMS has collected information on consumer satisfaction and health services experiences of beneficiaries enrolled in managed care health plans through annual implementation of the CAHPS survey in those plans. Since 2000, CMS has surveyed a cross-section of Medicare FFS enrollees using a CAHPS questionnaire designed to assess their satisfaction and experiences with regards to health care access, quality of care,

customer service, and services utilization. The primary purpose of both CAHPS surveys is to collect, analyze, and disseminate information to beneficiaries to help them in choosing between managed care health plans in the Medicare+Choice program and the Original FFS Medicare Plan program. Survey results also are used (together with clinical quality information and other available data) to monitor and evaluate the quality of care and relative performance of the Medicare program and assist in development of quality improvement initiatives for services delivered to Medicare beneficiaries.

Status: A contract modification to the CAHPS-FFS project, added in 2001, also permits development and testing of a CAHPS survey to be fielded among beneficiaries enrolled in private Medicare FFS health plans. Full implementation of this new component to the CAHPS-FFS Survey was added in Fall 2002 with reporting of information from this component to begin Fall 2003.

00-029 **Development of Databases, Data Processing, Data Analysis and Table Construction for Skilled Nursing Facility Refinement Project**

Project Officer: Carolyn Rimes
Period: May 2000–March 2002
Awardee: Jing Xing Technologies
Funding: $324,203

Description: This project uses files created for analysis to construct a file that presents the previous and newly created resource utilization groups for the purpose of analyzing the impact of the refined resource utilization groups on the skilled nursing facilities prospective payment system (SNF-PPS). SNF-PPS is a case-mix adjusted and wage-adjusted per diem payment system covering routine, ancillary, and capital costs. The development of the system was primarily based on administrative and staff time data, therefore one of these areas is ancillary care. CMS previously commissioned a study to explore possible refinements to the resource utilization groups. The study focused on the possible impact of ancillary care services on the resource utilization groups and detailed analysis of the more extensive care groups.

Status: The primary work is completed and is reflected in a paper prepared by Dr. Brian Fries, entitled "Analysis for SNF Refinement Project."

93-061 **Economic and Cost-Effectiveness Studies for the U.S. Renal Data System**

Project Officer: Joel Greer
Period: July 1993–September 2002
Awardee: National Institute of Diabetes and Digestive and Kidney Diseases
Funding: $1,657,075

Description: This interagency agreement (IAA) provided funds to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to support programmatic, economic, and cost-effectiveness studies by the coordinating center for the U.S. Renal Data System (USRDS). NIDDK contracted with the University of Michigan to be the coordinating center for 5 years. The IAA called for the coordinating center to conduct cost or cost-effectiveness components for at least four existing data studies and for one special study focused on economic issues each year.

Status: The IAA is completed. The USRDS published discussions, analyses, and data tables on cost and cost-effectiveness in the 1995, 1996, 1997, 1998 and 1999 USRDS Annual Data Reports. These reports are available from the National Technical Information Service (NTIS), on the Internet, and on CD-ROM. The NTIS accession number for the 1995 report is PB95-271391; the accession number for the 1996 report is PB97-111041; the 1997 through 1999 reports are replicated in their entirety on the Internet at http://usrds.org and also are available for minimal cost on CD-ROM. A new interagency agreement with NIDDK will provide support for an Economics Special Studies Center for the new five-year USRDS contract.

00-031 Assess the Impact of Requiring Parity for Mental Health

Project Officer: Frederick Thomas III
Period: June 2000–September 2003
Awardee: Office of the Assistant Secretary for Planning and Evaluation
Funding: $100,000

Description: This agreement supports an evaluation of the impact of requiring parity for mental health and substance abuse benefits within the Office of Personnel Management's (OPM) Federal Employees Health Benefits Program (FEHBP). For several years OPM has been interested in improving the mental health and substance abuse benefit in the FEHBP. OPM was directed to achieve full parity for these benefits by January 2001. There is substantial interest by various stakeholders in learning as much as possible about the effects of this change in coverage–particularly, the impact on access, utilization, quality and costs.

Status: Data collection and study design activities are in process.

02-058 Improving the Consistency of the Nursing Home Survey Process

Project Officer: Marvin Feuerberg
Period: September 2002–September 2003
Awardee: RAND Corporation
Funding: $248,355

Description: The purpose of this project is to assess the problem of inconsistency in the survey process and systematically link that assessment to specific policy and programmatic options for improvement. Specifically, the project will have four major components: 1) empirical assessment of variability and consistency of survey process; 2) identification of those aspects of inconsistency that are most troublesome; 3) empirical assessment of the most important causes of inconsistency; and 4) policy and programmatic options for improvement.

01-250 United States Renal Data Registry - II

Project Officer: Joel Greer
Period: March 2001–March 2003
Awardee: National Institute of Diabetes and Digestive and Kidney Diseases
Funding: $184,251

Description: This agreement provides support for the National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK, National Institutes of Health or NIH) contract with the Economic Studies Center of the United States Renal Data System (USRDS). This aspect of the USRDS work is for the conduct of cost effectiveness and other economic studies relevant to End Stage Renal Disease (ESRD). One special and four existing studies are supported annually by this project.

Status: This is an ongoing relationship between CMS and NIDDK.

02-076 Evaluation of the Illinois State Pharmacy Assistance Program

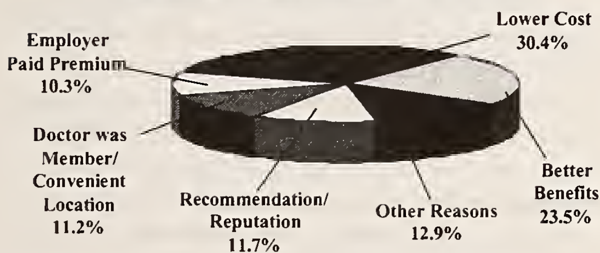
Project Officer: Rosemarie Hakim
Period: September 2002–September 2005
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,199,884

Description: This project will be an important first look at providing drug coverage to large numbers of Medicare beneficiaries. The goals of this project are to develop an understanding of the administration of a prescription drug benefit program and to developing an estimate of the cost effectiveness of providing prescription drug coverage to elderly beneficiaries. Specifically, it will conduct a descriptive evaluation, a cost-effectiveness analysis, and other analyses of specific aspects of the Illinois prescription drug demonstration.

Theme 2: Improving Managed Care Payment and Delivery

The Balanced Budget Act of 1997 created the Medicare+Choice (M+C) program, expanding beneficiary choices to include a broader range of coordinated care plans such as health maintenance organizations (HMOs), preferred provider organizations, provider-sponsored organizations, medical savings accounts, and private fee-for-service plans. Since 1997, CMS has been working to ensure a wide range of high-quality health care options for Medicare beneficiaries. As part of this effort, we continue to devote significant time and effort to better understanding the M+C program's successes and shortcomings. For example, we are developing systems for measuring beneficiary risk to refine capitated payments, and conducting demonstrations that test and evaluate the effectiveness of a wide range of capitated health plan arrangements to increase the choices available to Medicare beneficiaries. CMS research and demonstration projects include Medicare capitation demonstrations, Medicare capitation models that integrate acute and long-term care services, an examination of trends in HMO enrollment, and other aspects of M+C plan. In addition, we are examining programs to increase access and quality of health care for Medicaid beneficiaries and limit rising costs through the increased use of managed care.

Lower Costs or Better Benefits Were The Most Common Reasons for Joining a Medicare Risk HMO



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2001 Access to Care File.

00-110 Next Generation Medicare Managed Care Payment System

Project Officer: Benson Dutton
Period: September 2000–September 2002
Awardee: Urban Institute
Funding: $635,897

Description: This project assesses a possible "next generation" payment methodology (currently called the "Direct Model") for the Medicare+Choice (M+C) program. Under this direct model, managed care payments would move away (all or in part) from their current county FFS basis. In this direct payment approach, risk adjustment models could be calibrated using either a combination of FFS and managed care encounter data, or managed care data alone. This study presents a conceptual paper that describes and makes possible one possible approach to managed care payments without a fee-for-service (FFS)-based county rate book.

Status: This project was completed.

99-036 Evaluation of New Jersey Hospital Association Demonstration of Performance Based Incentives

Project Officer: Edgar Peden
Period: September 2002–September 2004
Awardee: Health Economics Research
Funding: $498,104

Description: The purpose of this evaluation is to provide CMS with timely feedback on the implementation and operational experience of the demonstration site. A case study methodology will be used to develop both qualitative and quantitative information required to assess the strengths and weaknesses of the demonstration.

Status: Formerly called "Evaluation of the Competitive Pricing Demonstration–Phase I".

01-285 Medicare/DoD Subvention Demonstration - Validation of Payment Reconciliation

Project Officer: Ronald Deacon
Period: July 2002–June 2002
Awardee: PriceWaterhouse Coopers
Funding: $84,759

Description: This project validates payment reconciliation at the end of the third year of the demonstration and related consulting services as needed.

98-236 Department of Defense Subvention Demonstration Evaluation

Project Officer: Victor McVicker
Period: September 1998–March 2002
Awardee: RAND Corporation
Funding: $1,411,439

Description: Under the demonstration, enrollment in the Department of Defense's (DoD) Senior Prime plan is offered to military retirees over age 65 who live within 40 miles of the primary care facilities of one of the six sites, have recently used military health facility services, and are enrolled in Medicare Part B. The Senior Prime plans must meet all relevant requirements for Medicare+Choice plans. Medicare makes a capitation payment to DoD for each enrollee, and DoD must maintain a level of effort for health care services to all retirees who are also Medicare beneficiaries, whether or not they choose to enroll, that is based on fiscal year 1996 DoD experience. The evaluation seeks to answer the basic question: can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to military-Medicare-eligible beneficiaries? The evaluation will seek the answer by examining issues in four basic areas: 1) enrollment demand; 2) enrollee benefits; 3) cost of the program; and 4) impacts on other DoD and Medicare beneficiaries.

Status: Reports are available from the National Technical Information Service (NTIS): accession numbers PB99 149056 and PB99 162505. In addition, General Accounting Office (GAO) Reports are available on the GAO website (http:// www.gao.gov): GAO/HEHS 99-39 and GGD-99-161.

97-030 Medicare Choices Demonstration: Verification of Encounter Data

Project Officer: Victor McVicker
Period: September 1997–September 2002
Awardee: MEDSTAT Group (DC)
Funding: $2,640,401

Description: This project ensures accurate and comprehensive encounter data are reported in the Medicare Choices Demonstration. It assesses the health plan information systems' capabilities, the overall reasonableness of the encounter data against benchmarks, and the validity of the encounter data against medical record information. On a quarterly basis and for each of the plans participating in the demonstration, a sample of enrollees is selected and medical records are examined to determine whether the information in the encounters (pseudo-claims) reflects what is in the medical record. Using the medical record, the project assesses the timeliness of the encounter data, the validity of the codes in the encounter data, and the completeness of the information.

Status: The data are being finalized to make the risk adjusted payments. The Medicare Choices Demonstration plans have had considerable difficulty supplying encounter data that is in the correct format and that contains all the required information to the FIs and carriers. As a result, most of Medstat's efforts have been directed at providing technical assistance to the plans rather than performing the medical record reviews as originally planned.

98-237 Evaluation of the Medical Savings Account Demonstration

Project Officer: Renee Mentnech
Period: September 1998–September 2003
Awardee: Barents Group
Funding: $6,546,119

Description: This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries. The contractor will also act as a coordinator between CMS and the demonstration participants, including beneficiaries and health plans, in order to ensure that accurate, reliable, and complete data are collected.

Status: To date, no insurers have elected to participate in the MSA Demonstration. In light of this development, a report is being prepared on the reasons for this lack of interest.

00-111 Survey of Medicare Beneficiaries Who Were Involuntarily Disenrolled from HMOs that Withdrew from Medicare or Reduced their Service Areas

Project Officer: Gerald Riley
Period: September 2000–October 2002
Awardee: University of Wisconsin - Madison
Funding: $551,823

Description: This project involved development and implementation of a survey that asks about the experience of beneficiaries whose plans withdrew from Medicare or reduced their service areas in January 2001. As a result, Medicare beneficiaries were disenrolled involuntarily and had to enroll in another health maintenance organizations (HMOs) or go to fee-for-service (FFS). This project studies the impact of the HMO withdrawals on the beneficiary population. Beneficiaries are asked: what insurance arrangements they made after their plan withdrew from Medicare or reduced its service area; how their benefits and out of pocket costs were affected by new arrangements necessitated by their plan's withdrawal; and whether they had to change doctors. The survey was conducted by mail with telephone follow-up and consists of 20-30 questions.

Status: The survey specifically addressed what type of new insurance arrangements beneficiaries made; what their informational needs were; disruptions to patterns of care; changes in benefits; changes in out of pocket costs; psychological impacts; and differences among subgroups of beneficiaries. Approximately 3,400 beneficiaries responded. Preliminary analyses indicated that most beneficiaries found the information they received about the withdrawals to be adequate, but there were clear information and understanding gaps among beneficiaries regarding the options available to them and the implications of plans withdrawing from Medicare.

97-022 Capitation Demonstration, Evaluation

Project Officer: Joel Greer
Period: August 1997–May 2002
Awardee: Lewin Group
Funding: $2,442,533

Description: The project uses survey, claims, and medical records data to evaluate the efficacy and cost-effectiveness of permitting Medicare beneficiaries with End Stage Renal Disease (ESRD) to enroll in managed care.

Status: Preliminary analyses are completed.

02-055 Investigation of Increasing Rates of Hospitalization for Ambulatory Care Sensitive Conditions among Medicare Beneficiaries

Project Officer: Mary Kapp
Period: September 2002–March 2004
Awardee: Research Triangle Institute, (DC)
Funding: $172,671

Description: The purpose of this project is to examine trends in the rates of inpatient hospital care of the elderly for ambulatory care sensitive conditions (ACSC) or "avoidable hospitalizations." This project uses existing Medicare data to examine the nature of the increases in ACSC hospitalizations, identify the sub-populations most affected, and explore more fully the reasons for these trends, with particular emphasis on policy issues which offer promise to reverse the trends. CMS data also provide sufficient sample size to permit investigation of supply factors, access issues, and geographic patterns.

96-083 **End Stage Renal Disease (ESRD) Managed Care Demonstration: Health Options**

Project Officer: Bonnie Edington
Period: September 1996–December 2002
Awardee: Advanced Renal Options
Funding: $0

Description: The original demonstration program, Advanced Renal Options, tested whether open enrollment of End Stage Renal Disease (ESRD) patients in managed care was feasible with a capitation rate adjusted for age, treatment status, and cause of renal failure, and additional payment made for extra benefits.

Status: Data collection for evaluation purposes ended May 2001, at the conclusion of the mandated 3-year period, and the evaluation report was due May 2002. Waivers were renewed for the period June 2001 through December 2002 for residual demonstration enrollees to continue to receive the extra benefits, with CMS paying an unadjusted capitation rate based on the demonstration rate.

01-168 **Pilot Test and Analysis of the Medicare Health Survey for Program for All-Inclusive Care for the Elderly (PACE) and EverCare (MHSPE)**

Project Officer: Ron Lambert
Period: September 2001–September 2004
Awardee: Health Economics Research
Funding: $428,922

Description: The purpose of this project is to determine the feasibility of implementing a variant of the Health Outcome Survey (HOS) for organizations that serve special populations, such as the Program of All-Inclusive Care for the Elderly (PACE) and EverCare. CMS developed a variant of the HOS for use with frail Medicare beneficiaries enrolled in specialty plans. This survey was intended to serve as a means to compare outcome measures across Medicare+Choice and specialty plans and to support further research on payment to specialty plans. The primary goals of the Medicare Health Survey for PACE and EverCare (MHSPE) were: to improve response rates over the experience of the 1999 HOS and to more accurately describe the health and functional status of the target populations. CMS will pilot test the MHSPE on a subset of PACE and EverCare enrollees. This current project will: 1) administer the MHSPE to a sample of PACE and EverCare enrollees; 2) collect and validate MHSPE pilot survey data; and 3) perform the appropriate analysis to measure the impact on response rates of various approaches administered under the pilot survey.

Status: To assess the feasibility of applying HOS to specialty plans, the survey was administered to PACE and EverCare on a pilot basis in 1999. The response rates to the HOS for these plans were significantly below the response rates for the Medicare+Choice program.

96-056 **Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance**

Project Officer: Mary Wheeler
Period: September 1990–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $3,203,917

Description: The purpose of this project is to develop a core data set that is the foundation for an outcome-based quality improvement (OBQI) system for the Program of All-Inclusive Care for the Elderly (PACE) program. The OBQI system consists of two phases during which the PACE sites complete the data instrument that contains items for outcome measurement and risk adjustment at specific time intervals. Using the data collected in the first phase, site-level reports can be produced summarizing the outcome measures. By comparing site-level case-mix adjusted outcome reports to other PACE site outcome reports, and to the site's previous outcome reports from earlier time periods, the site, CMS, and the State Medicaid agencies are able to identify areas that require further examination due to inferior (or perhaps superior) outcomes. In the second phase, the sites take a closer look at why and how the specific outcomes are

achieved and makes recommendations for improvements in the case of poor (or perhaps superior) outcomes.

Status: Significant progress has been made in the development of outcome indicators for PACE. The OBQI contract was modified in October 1999, which expanded the period of performance and increased the level of effort to support the development of a Core Comprehensive Assessment (COCOA) instrument for PACE providers. Although this change in the timeline will delay the OBQI component, the burden of data collection on the PACE sites will be decreased.

01-214 Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration

Project Officer: Frederick Thomas III
Period: September 2001–September 2003
Awardee: Mathematica Policy Research, (Princeton)
Funding: $819,772

Description: This is an evaluation of the Program for All-Inclusive Care for the Elderly (PACE) program. The evaluation studies PACE as a demonstration project, as a permanent program under Medicare, and as an option under Medicaid. This project first evaluates in terms of: site attributes, patient characteristics, and utilization data statistically analyzed across sample sites and compared to the prior demonstration data. This project expands on the foundations laid in the previous evaluations of PACE by predicting costs beyond the first year of enrollment, assessing the impact of higher end of life costs and long term nursing home care, and assessing the impact of local treatment practices. Secondly, for the evaluation of the for-profit demonstration, the specific questions from the Balanced Budget Act should be answerable by comparing site attributes, patient characteristics, and utilization data of the permanent PACE providers to the for-profit demonstration providers.

Status: Phase I was extended to September 2003.

02-052 Integrated Payment Option Support Contract

Project Officer: Raymond Wedgeworth
Period: September 2002–September 2006
Awardee: Research Triangle Institute, (DC)
Funding: $496,279

Description: This demonstration utilizes the capabilities of integrated delivery systems by offering them 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 will compare alternate methods for calculating payment rates using different assumptions such as, co-morbid conditions, stage of diagnosis, and mix of services.

Status: CMS plans to implement the Integrated Payment Option demonstration in January 2004. CMS will select premier integrated delivery systems and give a bundled Part A & Part B payment (global payment) for all inpatient facility, post-acute and physician services related to 3-5 specific DRGs. Six to 8 sites will be selected.

Second Generation Social Health Maintenance Organization Demonstration

The purpose of the second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics.

99-271 Second Generation Social Health Maintenance Organization Demonstration: Florida

Project Officer: James Hawthorne
Period: May 1998–June 2002
Awardee: Florida, Department of Elder Affairs
Funding: $150,000

Description: This project funds the Florida State Department of Elder Affairs purchase of technical assistance and planning activities for a second generation social health maintenance organization (SHMO). The goal of this project is to study the feasibility of implementing a Second Generation SHMO in Florida and, should this prove feasible, to develop the specifications needed for the State to issue a Request for Proposal.

Status: A second 12-month no-cost extension was approved extending the period of performance to June 2002.

84-007 Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan

Project Officer: Thomas Theis
Period: August 1984–August 2003
Awardee: SCAN Health Plan
Funding: $0

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.

Status: 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 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration. The Benefits Improvement and Protection Act of 2000 further extended the demonstration. 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.

95-088 Second Generation Social Health Maintenance Organization Demonstration: Nevada

Project Officer: Thomas Theis
Period: November 1996–August 2003
Awardee: Health Plan of Nevada, Inc.
Funding: $0

Description: The purpose of this second-generation social health maintenance organization (S/HMO-II) demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute and long-term-care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. The S/HMO-II model provides an opportunity to test models of care focusing on geriatrics. The Health Plan of Nevada is one of six organizations originally selected to participate in the project.

Status: The Balanced Budget Act of 1997 extended the demonstration period through December 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration. The Benefits Improvement and Protection Act of 2000 further extended the demonstration. 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. Health Plan of Nevada (HPN) is the only operational site in

the demonstration. HPN began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 2001 was over 38,000 members.

84-006 **Social Health Maintenance Organization Project for Long-Term Care: Kaiser Permanente Center for Health Research**

Project Officer: Thomas Theis
Period: August 1984–August 2003
Awardee: Kaiser Permanente Center for Health Research
Funding: $0

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.

Status: Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II used Medicare waivers only. The Balanced Budget Act of 1997 extended the demonstration period through December 2000. The Balanced Budget Refinement Act of 1999 extended the demonstration. The Benefits Improvement and Protection Act of 2000 further extended the demonstration. 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.

84-004 **Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)**

Project Officer: Thomas Theis
Period: August 1984–August 2003
Awardee: Elderplan, Inc.
Funding: $0

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.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan 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 Benefits Improvement and Protection Act of 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.

97-210 Data Collection for Second Generation SHMO

Project Officer: Thomas Theis
Period: November 1996–December 2003
Awardee: Lewin Group
Funding: $7,052,998

Description: This project consolidated the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. The project conducted initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered served three primary functions: 1) baseline and follow-up data for the analyses; 2) clinical information to the participating S/HMO-II sites for care planning; and 3) data for risk-adjustment. In addition, this project supports a Congressionally mandated requirement for an evaluation component and formal Report.

Status: While multiple sites were originally planned for this demonstration, only one, the Health Plan of Nevada, actually implemented a SHMO II plan. The evaluation is designed to assess the impact of the SHMO II by comparing it with regular Medicare+Choice sites using measures of utilization, quality of care, and changes in participant health status over time. Reports to Congress were due November 2002.

97-018 Age Well Option (now referred to as TLC)

Project Officer: William Clark
Period: May 1997–April 2002
Awardee: Hebrew Rehabilitation Center for the Aged
Funding: $600,000

Description: In this project, community care and educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management. The populations studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston community. Educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decision-making, and chronic disease management.

Status: In progress.

97-216 Evaluation of the Evercare Demonstration Program

Project Officer: John Robst
Period: September 1997–March 2002
Awardee: University of Minnesota, (Wash Ave)
Funding: $1,544,142

Description: For each of the five EverCare sites, two comparison groups were selected–1) nonparticipating residents in EverCare site nursing homes and 2) residents in nonparticipating nursing homes operating in EverCare demonstration cities.

Status: Site visits have been made to EverCare and non-EverCare facilities in each of the participating sites. A survey of Ever Care residents, proxies for residents, and control group nursing home residents has been conducted. Data are currently being analyzed. A final evaluation report was expected in late 2001.

00-085 Ambulatory Care Sensitive Conditions - II

Project Officer: Jennifer Harlow
Period: September 2000–March 2002
Awardee: Health Economics Research
Funding: $171,736

Description: The purpose of this task order is to further refine and validate hospital discharge rates for Ambulatory Care Sensitive Conditions (ACSCs) and develop a method for case-mix adjusting the ACSC rates at the Medicare+Choice (M+C) organization level. An ACSC is a hospitalization which was potentially avoidable with the provision of timely and effective ambulatory care. These tasks will be conducted using M+C inpatient encounter data

submitted to CMS for the period July 1997 though June 1998 and also fee-for-service (FFS) claims data for the same time frame. The presence of an ACSC provides an indication that an individual may not have been receiving appropriate ambulatory care. The preliminary research using one year of M+C encounter data has shown that the rates can be applied at the M+CO level to evaluate the provision of care; however, before the ACSC rates can be used as a measure to evaluate M+CO performance, the rates should be further refined and validated for the population over age 65. Additionally, in order to compare rates of ACSCs at the M+CO level, a method for case-mix adjusting rates needs to be developed in order to account for variation in the health status of M+CO enrollees.

Status: The contractor has conducted data analyses and has produced draft reports on the refinement of different ACSC indices and case-mix adjustment.

00-019 Risk Adjustment Implementation for Medicare Demonstrations

Project Officer: Victor McVicker
Period: September 1999–March 2002
Awardee: Fu Associates
Funding: $68,426

Description: This project provides technical assistance regarding risk adjustment to Medicare Choices Demonstration, Department of Defense Subvention Demonstration, Social Health Maintenance Organizations Demonstration I, and Social Health Maintenance Organizations Demonstration II populations.

Status: A modification to the contract provides an additional task for the contractor to calculate risk adjuster scores for the treatment and control groups used in the evaluation of the Community Nursing Organization demonstration.

02-060 Refinements to Medicare Diagnostic Cost Group (DCG) Risk Adjustment Models

Project Officer: Melvin Ingber
Period: September 2002–September 2004
Awardee: Boston University
Funding: $568,038

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations was developed under contract with CMS (#500-92-0020 Task Order 6), and were then further improved (#500-95-0048 Task Order 3). This task order will test the model for use in special populations to develop satisfactory payment for plans that enroll beneficiaries selectively based on their medical, functional or institutional condition. The DCG-based models are designed to use demographic and diagnostic information to project expenditures and to provide factors that could be used to multiply the ratebook amounts instead of the demographic factors currently used.

96-211 Refinements to Medicare Diagnostic Cost Group Risk Adjustment Models

Project Officer: Melvin Ingber
Period: September 1996–July 2002
Awardee: Health Economics Research
Funding: $845,277

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations has been developed and subsequently improved. This project further updates the models with newer data (1995-1996) and provides better adjustment for factors such as "working aged" and "institutionalized." These risk adjuster models go beyond demographic information in adjusting payments to include clinical information from medical claims, which is used to modify payment to reflect the expected expenditures for each enrollee. The diagnostic-cost-group (DCG) family of models is the most mature set of risk adjusters available and uses demographic, diagnostic, and procedure information to project expenditures and

provide adjusters that could be used to multiply the rate book amounts instead of the demographic factors.

Status: BBA required a hospital-based model be used by year 2000.

01-283 Testing Comprehensive Risk Adjustment Models for Coding Gameability

Project Officer: John Robst
Period: August 2001–April 2002
Awardee: Park Nicollet Institute
Funding: $215,116

Description: This will assist in assessing and evaluating five different risk adjustment models based on whether providers' discretion over coding may influence payment (gameability). Specifically, the project will convene a series of provider panels to address the gameability issue. In the assignment of codes from the International Classification of Diseases, Ninth version, Clinical Modification, providers have some legitimate discretion over the selection of the appropriate diagnosis that can be assigned to reflect the severity of the illness and to identify the presence of conditions. Within the range of defensible diagnoses, some codes generate higher payments than others, and providers could have an incentive to choose the code that gives the higher payment. To the extent that coding patterns shift from the one used as the basis for calibrating a risk adjustment model, such changes in coding would result in overpayments. The project will identify codes where there is room for discretion. It will then review the risk adjustment models to determine whether the logic of each model's grouping is more or less vulnerable to gaming through coding choices. The project's focus is not fraudulent assignment of diagnostic codes but on the legitimate possibilities available within normal clinical and coding practices.

Status: Diagnostic codes have been identified for consideration by the expert panels. A pilot evaluation of two conditions has been conducted. The contractor is recruiting expert panels for the remaining conditions.

02-059 Survey of Renal Dialysis Centers

Project Officer: Mary Stojak
Period: September 2002–February 2003
Awardee: University Renal Research and Education Association
Funding: $145,844

Description: The purpose of the task order is to measure the amount and quality of nutrition therapy that is currently being provided to beneficiaries receiving dialysis.

00-064 Evaluation of Community Nursing Organization (CNO) Demonstrations, Phase II

Project Officer: Victor McVicker
Period: September 2000–September 2002
Awardee: Abt Associates
Funding: $246,367

Description: This project evaluates the design and implementation of Phase II of the Community Nursing Organization (CNO) Demonstration. The Phase I evaluation covers the initial period of operation of the demonstration. The Phase II evaluation provides for longer term followup of early participants and also includes an assessment of the effects of the CNO intervention on later participants whose data were not available for Phase I evaluation. The Phase II evaluation requires the use of hierarchical-coexisting-conditions risk adjusted estimates of Medicare expenditures for Medicare beneficiaries who participated in the demonstration, as well as for a new comparison group. The calculation of the risk adjuster scores is being contracted separately and the resulting data will be made available to this Phase II evaluation.

Status: The demonstration has been extended several times, most recently by section 532 of the Balanced Budget Refinement Act (BBRA) of 1999, which extended the demonstration through December 2001, and mandated an additional evaluation of the demonstration. Section 632 of the Benefits Improvement and Protection Act of 2000 replaced the mandated evaluation required by section 532 of BBRA

with a preliminary report due to Congress by July 2001 and a final report to Congress by July 2002.

98-234 **Decisionmaking in Managed Care Organizations**

Project Officer: Brigid Goody
Period: July 1998–August 2002
Awardee: Health Economics Research
Funding: $257,749

Description: This task order examines a broad range of managed care decision-making strategies, their implications for the development and diffusion of new technologies and their impact on future health care costs, especially Medicare program costs. The project had three phases. First, case studies of managed-care organizations focused on components of plan decision-making related to the scope of insurance coverage: benefits offered, premium and coinsurance structure, and coverage of specific technologies. Second, it examined how the research and development decisions of private firms are affected by increased managed care penetration. Third, it developed a conceptual framework for simulating the long term growth in health care expenditures, especially Medicare program costs, which incorporates the interaction between increased managed care penetration and the research and development process.

Status: A final report presenting findings from the interviews with managed care organizations, contracting hospitals and research and development companies has been received. They found that, while managed care plans attempt to control use of certain technologies, their ability to do so is more restricted than expected. Similarly, managed care undoubtedly influences manufacturer research-and-development investment decisions through coverage and payment policies. It is, however, not clear that it has changed the likelihood that cost-increasing technologies will come to market, nor has it altered the fundamental feedback relationship among insurance, technological innovation, and health care expenditure growth.

00-123 **Data Collection to Support Policy Analysis of Choices Offered to Medicare+Choice Enrollees and Choices Made by Enrollees**

Project Officer: Carlos Zarabozo
Period: September 2000–July 2002
Awardee: Actuarial Research Corporation
Funding: $140,185

Description: This project collects data from Medicare+Choice (M+C) organizations regarding the benefits offered to enrollees of M+C plans and the choices that Medicare beneficiaries make as M+C enrollees. The project will collect information about: 1) The number of Medicare beneficiaries in each M+C organization whose M+C benefit package is supplemented or paid for by a (former) employer or union, and how the benefit offerings of employment-based Medicare retiree coverage compare to the benefit offerings of individual Medicare enrollees of the organization; and 2) The choices made by current and new enrollees when the M+C organization offers multiple benefit packages in a particular county.

Status: The survey was fielded in January of 2002, with results available June of 2002.

02-082 **Refinement of Risk Adjustment for Special Populations**

Project Officer: Ronald Lambert
Period: August 2002–July 2004
Awardee: Health Economics Research
Funding: $399,740.44

Description: This project will review and evaluate potential risk adjusters and develop a preliminary payment approach for frail populations. One of the purposes of this contract modification is to refine and further develop frailty adjustment. In 2000, CMS implemented a risk adjustment methodology that uses hospital inpatient diagnoses, and pays Medicare+Choice (M+C) organizations a blend of 10 percent of the risk adjustment amount and 90 percent of the previous demographic payment amount. The payment approaches under consideration

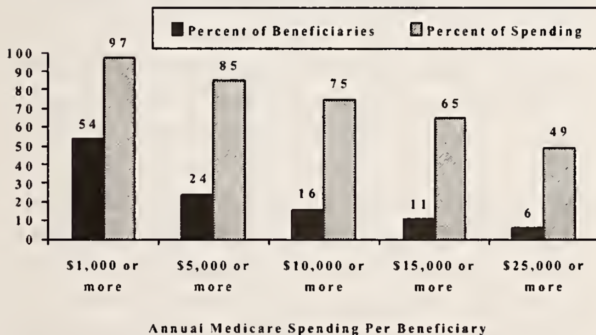
involve the application of a frailty adjuster in conjunction with the inpatient and ambulatory model that will be used for M+C organizations in 2004.

Status: CMS is considering implementing frailty adjustment for demonstrations and PACE in 2004. Prior to implementation, CMS will be sharing information with the demonstrations, PACE, and other interested parties and pursuing clearance through the Office of Management and Budget (OMB) and the Department of Health and Human Services. Refinements and further development will be necessary to reflect more recent research or changes in policy direction. This is a modification to existing contract with Health Economics Research (HER, #500-99-0038).

Theme 3: Improving Fee-For-Service Payment and Delivery

CMS is working to ensure a wide range of high-quality health care options for Medicare beneficiaries. Improving fee-for-service payment and delivery involves activities that support efforts to modernize the program and explore how Medicare can adopt successful innovations of private purchasers. We test approaches that provide opportunities and appropriate incentives for coordination of complex care and that reward cost-effective decisions on the part of beneficiaries and providers. CMS projects include: coordinated care models, prospective payment for post-acute care services, payment systems focused on vulnerable populations, implementing and evaluating the durable medical equipment consumer direct purchasing demonstration, aligning hospital and physician incentives by using an all inclusive payment for hospital and physician services, competition-based payment models, bonus payments for health care groups, preferred provider arrangements, evaluating the graduate medical education payment alternative demonstration, assessing the impact of private contracting on beneficiaries and providers, evaluating work and practice expense of physicians, and evaluating rural telemedicine projects.

Six Percent of Beneficiaries Account for Nearly 50 Percent of Program Spending



Source: *CMS, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.*

02-064 Evaluation of Programs of Disease Management (Phase I and Phase II)

Project Officer: Carol Magee
Period: September 2002–September 2007
Awardee: Mathematica Policy Research, (DC)
Funding: $1,908,308

Description: The objective of the evaluation is to assess the effectiveness of disease management programs for serious chronic medical conditions such as advanced stage diabetes and congestive heart failure (CHF). Although the participating demonstration sites may also vary by classification of disease severity, the availability of a pharmacy benefit, population targeted, scope of patient care covered, type of comparison group and other factors, they will have in common the goal of improving quality and reducing cost of health care received by chronically ill Medicare beneficiaries through specific services targeted to the management of a particular medical condition. The evaluation will study the independent effects of both the disease management program and a drug benefit as well as any interaction between the two.

Status: RTOP issued to RADSTO Medicare May 16, 2002.

02-066 Payment Development, Implementation, and Monitoring Support for the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management Demonstrations

Project Officer: J. Donald Sherwood
Period: September 2002–September 2007
Awardee: Actuarial Research Corporation
Funding: $453,557

Description: The purpose of this task is to support CMS in implementing a demonstration project in three or more sites to provide disease management services to Medicare beneficiaries with advanced stages of congestive heart failure, coronary heart disease, and/or diabetes. Specifically, this project 1) provides general technical support in the analysis of rate proposals and

assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects; 2) educates demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements; 3) monitors 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) performs financial analysis to assist in the financial settlement and reconciliation.

98-256 Medicare Clinical Laboratories Competitive Bidding Demonstration Planning and Technical Assistance

Project Officer: Michael Park
Period: September 1998–September 2002
Awardee: Research Triangle Institute, (DC)
Funding: $883,568

Description: The project evaluates Part B laboratory test charges in order to calculate a relative value scale. This is a first step toward the development of a process for refining the fee schedule. The development of a final relative value scale is beyond the scope of this study. The current project work is limited to analyzing current laboratory charge data to help inform potential policies.

Status: This project was initially intended to provide support in the implementation and operation of the clinical lab competitive bidding demonstration, and the development and evaluation of models for bidding of Part B services other than physician services, lab services, and durable medical equipment. The focus of the study is in response to the Institute of Medicine report entitled "Medicare Laboratory Payment Policy: Now and in the Future."

01-111 Environmental Scan for Selective Contracting Practices with Efficient (Qualified) Physicians and Physician Group Practices; Profiling Techniques; Incentive Payments and Barriers to Selective Contracting

Project Officer: Benson Dutton
Period: September 2001–March 2003
Awardee: Health Economics Research
Funding: $303,803

Description: This project undertakes an environmental scan of physician service payers/employers to identify (a) recent fee-for-service payer and managed care plan selective contracting arrangements with efficient/high quality physicians and physician-group practices; (b) best practice profiling methodology/criteria used in selective contracting including financial profiling; (c) barriers to selective contracting such as "any-willing-provider" or "freedom-of-choice" laws; and (d) bonus arrangements being paid to high quality physicians. Descriptive and qualitative analyses based on this environmental scan should lead to a recommendation of best practice profiling criteria that identify efficient and qualified physicians and group practices. Quantitative analyses estimate current Medicare (Part B) physician expenditures and simulate possible program savings (losses) from alternative selective contracting policies based on best industry practice found in the environmental scan. The use of physician profiling (quality and economic) by payers and employers in evaluating physicians for the purposes of staff appointment, reappointment, and/or selective contracting has been suggested as an accepted industry practice that would modernize Medicare payment practices. In addition, the use of bonus payments to efficient and high quality physicians to keep Medicare program costs down and quality of service up is cited as another industry practice appropriate for modernization of Medicare.

Status: The contractor presented work on research methods and examples of private sector physician efficiency profiling at the Diagnostic Cost Group conference in Boston.

96-081 Evaluation of Group-Specific Volume Performance Standards Demonstration

Project Officer: John Pilotte
Period: September 1996–September 2002
Awardee: Health Economics Research
Funding: $2,220,440

Description: The purpose of this task order is to comprehensively evaluate the Group-Specific Volume Performance Standards Demonstration. Additionally, there is a group of tasks to provide technical support for setting sites' targets and measuring their actual performance. The goal of the demonstration is to test the feasibility of this partial-risk-bearing payment arrangement between CMS and qualifying physician-based organizations in the fee-for-service (FFS) market, whereby FFS rules apply within the context of a performance target, beneficiaries are not enrolled, and physician-sponsored organizations develop structures and processes to manage the services and cost of care received by FFS patients.

Status: In developing the final design parameters of the GVPS demonstration, simulations were conducted to analyze low and high expenditure outliers, eligibility mix changes, components of growth rates by type of service, and effects of case-mix adjustments. These analyses reveal sources of variability in growth rates, and support development of options for setting targets and calculating updates and bonus payments. The evaluator is awaiting the initiation of the demonstration.

00-117 Evaluation of the Informatics, Telemedicine, and Education Demonstration

Project Officer: Carol Magee
Period: September 2000–July 2004
Awardee: Mathematica Policy Research, (Princeton); Urban Institute
Funding: $1,419,493

Description: The Balanced Budget Act of 1997 mandates a single, 4-year demonstration project using an eligible health care provider telemedicine network. The demonstration involves the application of high-capacity computing and advanced telemedicine networks to the task of improvement of primary care and prevention of health complications in Medicare beneficiaries with diabetes mellitus. This project evaluates the impact of using telemedicine and medical informatics on improving access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of beneficiaries. The Informatics, Telemedicine, and Education Demonstration project uses specially modified home computers, or home telemedicine units (HTU) linked to a Clinical Information System (CIS), and studies beneficiaries residing in medically under-served rural or medically under-served inner-city areas. The HTUs in patients' homes allow video conferencing, access to health information, and access to medical data, in both Spanish and English. The demonstration project is being conducted as a randomized, controlled clinical trial. Impact of the telemedicine intervention on health outcomes will be evaluated by comparing health outcome measures of the intervention group to a control group.

Status: This evaluation began in November 2001. The evaluator and the demonstration consortium are arranging for the initial site visits and personnel interviews in order to accomplish the descriptive component of this evaluation. Over the last year, CMS and the Columbia Consortium have been negotiating the details surrounding data-sharing, site-access, and publication rights.

00-166 Informatics, Telemedicine, and Education Demonstration

Project Officer: Lawrence Kucken
Period: February 2000–February 2004
Awardee: Columbia University
Funding: $17,356,211

Description: 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 website for the project. The consortium is led by Columbia University. Intervention participants receive a home telemedicine unit which facilitates uploading of clinical data, interaction with a nurse case manager, and patient education.

Status: The experience to date indicates that large scale home telemedicine as a strategy for disease management is technically feasible, can be done in a fashion that meets current requirements for health care data security, and is highly acceptable to those who agreed to participate in this study. No evidence has been found to indicate that Medicare beneficiaries living in federally-designated, medically-underserved areas are unable or unwilling to use computers or the World Wide Web to obtain health care information and health care services.

95-023 Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine

Project Officer: Joel Greer
Period: September 1995–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $2,198,968

Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves ten rural hospitals, one rural referral hospital, and one urban hospital. Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of the project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment, patients and providers being as satisfied with telemedicine as with on-site services, telemedicine services being less costly than on-site services, and telemedicine improving access to a wider range of health care services.

Status: A revised OMB approval was obtained, valid until June of 2001. Additional research projects are being considered. The demonstration to be evaluated encountered significant problems, and this forced the evaluator to revise its approach.

00-113 Evaluation of Programs of Coordinated Care and Disease Management

Project Officer: Amy Knight
Period: September 2000–September 2005
Awardee: Mathematica Policy Research, (DC)
Funding: $3,018,839

Description: This project evaluates a group of Congressionally mandated demonstration programs and two Agency-initiated demonstration programs. The demonstrations test various methods of managing care in the fee-for-service (FFS) Medicare environment. Demonstration of the effectiveness of programs of care coordination or management are complicated, not only by wide variations in program staff, funding mechanisms, interventions and stated goals, but by the evaluator's definition(s) of effectiveness. CMS is investigating the potential of care coordination or case management to improve care quality and control costs in the Medicare FFS program. Under the Balanced Budget Act of 1997, a demonstration of approaches to coordinated care of chronic illnesses in up to nine separate sites is required. An evaluation of best practices in coordinated care and a study of demonstration design options was conducted.

A separate demonstration, the Medicare Case Management Demonstration, focuses on programs of case management specific to diabetes and congestive

heart failure. This evaluation assesses the effectiveness of various strategies for coordinating care in the FFS Medicare environment, in a total of 11 demonstration sites. The participating demonstration sites vary by: corporate structure, types of medical conditions addressed, scope of patient care covered, beneficiary eligibility, and source of comparison data.

Status: The contractor is working with the demonstration sites to finalize randomization procedures and is completing the design of the patient and physician surveys in preparation for submitting an OMB approval package.

00-082 Implementation Support for the Medicare Coordinated Care Demonstration

Project Officer: Cynthia Mason
Period: September 2000–March 2005
Awardee: KPMG Consulting
Funding: $2,012,184

Description: This project provides CMS with technical monitoring and assistance in project implementation and operation of the Medicare Coordinated Care Demonstration. The demonstration tests models of coordinated care (case management and disease management) that seek to improve the quality of services provided to beneficiaries who have a chronic illness and manage expenditures of the Medicare program.

Status: This support contract is meeting with sites and conducting training sessions on billing and cost reporting.

99-068 Aging in Place: A New Model for Long-Term Care

Project Officer: Barbara Silverman
Period: June 1999–June 2003
Awardee: Curators of the University of Missouri, Office of Sponsored Program Administration, University of Missouri - Columbia, Sinclair School of Nursing
Funding: $2,000,000

Description: The goal of the "Aging in Place" model of care for frail elderly is to allow elders to remain in their homes as they age, rather than requiring frequent moves to allow for more intensive care if and when it becomes necessary. Although a planned element of the program is a new senior housing development, the program currently targets elderly residents of existing congregate housing.

Status: As a result of changes to the study plan, the applicant requested an increase in the first-year award with a corresponding reduction in the Years 2-4 awards and no change in the total budget. This change was approved.

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

This demonstration is testing whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among certain beneficiaries that 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 a pilot project to provide case management and disease management services to certain Medicare FFS beneficiaries with complex chronic conditions. This project and the other 14 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 (BBA) authorizes this demonstration to test existing models of coordinated care interventions to improve the quality of services provided to certain chronically ill beneficiaries and manage expenditures to the Medicare program. The Act requires that the projects target chronically ill Medicare FFS beneficiaries that are eligible for both Medicare Parts A and B and requires that the projects' payment methodology be budget neutral.

01-042 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Washington, DC

Project Officer: John Pilotte
Period: February 2001–January 2006
Awardee: Georgetown University
Funding: $0

Status: Implementation began in early 2002.

01-040 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Pennsylvania

Project Officer: Michael Park
Period: February 2001–March 2006
Awardee: Health Quality Partners
Funding: $0

Status: Implementation began in early 2002.

01-028 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Maine

Project Officer: Sidd Mazumdar
Period: February 2001–January 2006
Awardee: Medical Care Development
Funding: $138,720

Status: Implementation began in early 2002.

01-029 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Mahomet, Illinois

Project Officer: Dennis Nugent
Period: February 2001–January 2006
Awardee: Carle Foundation Hospital
Funding: $149,943

Description: This demonstration site works with the Carle Foundation Hospital of Mahomet, Illinois. It implements a rural case management program targeting beneficiaries with various chronic conditions in eastern Illinois.

Status: Implementation began in early 2002.

01-032 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Florida

Project Officer: Kathy Headen
Period: February 2001–January 2006
Awardee: Quality Oncology, Inc.
Funding: $63,000

Description: This demonstration site works with Quality Oncology, Incorporated of McLean, Virginia. It implements an urban disease management program focusing on beneficiaries with cancer in Broward County, Florida

Status: Implementation began in early 2002.

01-031 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Richmond, Virginia

Project Officer: Cynthia Mason
Period: February 2001–January 2006
Awardee: CenVaNet
Funding: $75,448

Description: This demonstration site works with CenVaNet, Incorporated of Richmond, Virginia. It implements an urban case management program targeting beneficiaries with various chronic conditions in Richmond.

Status: Implementation began in early 2002.

01-041 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–South Dakota

Project Officer: Sidd Mazumdar
Period: February 2001–January 2006
Awardee: Avera McKennan Hospital
Funding: $0

Status: Implementation began in early 2002.

01-039 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–New York, NY

Project Officer: Dennis Nugent
Period: February 2001–January 2006
Awardee: The Jewish Home and Hospital for the Aged
Funding: $150,000

Description: This demonstration site works with The Jewish Home and Hospital for the Aged. It implements an urban case management program targeting beneficiaries with various chronic conditions in New York City.

Status: Implementation began in early 2002.

01-037 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Houston, Texas

Project Officer: John Pilotte
Period: February 2001–January 2006
Awardee: CorSolutions Medical, Inc.
Funding: $82,350

Status: Implementation began in early 2002.

01-036 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–University of Maryland

Project Officer: Dennis Nugent
Period: February 2001–January 2006
Awardee: University of Maryland, School of Medicine
Funding: $0

Description: This demonstration site works with the University of Maryland School of Medicine. It implements an urban disease management program targeting beneficiaries with congestive heart failure in Baltimore, Maryland.

Status: Implementation began in early 2002.

01-035 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Baltimore, Maryland

Project Officer: Kathy Headen
Period: February 2001–January 2006
Awardee: Erickson Retirement Community, Inc.
Funding: $45,100

Description: This demonstration site works with Erickson Retirement Communities, Incorporated. It implements an urban case management program targeting beneficiaries with congestive heart failure, coronary artery disease, hypertension, or diabetes living at Charlestown and Oak Crest Village Retirement Communities located in Baltimore County, Maryland

Status: Implementation began in early 2002.

01-034 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Massachusetts

Project Officer: Michael Park
Period: February 2001–January 2006
Awardee: Washington University Physician Network
Funding: $150,000

Status: Implementation began in early 2002.

01-033 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Iowa

Project Officer: Sidd Mazumdar
Period: February 2001–January 2006
Awardee: Mercy Medical Center - North Iowa
Funding: $50,000

Status: Implementation began in early 2002.

01-030 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Arizona

Project Officer: Michael Park
Period: February 2001–January 2006
Awardee: Hospice of the Valley
Funding: $0

Status: Implementation began in early 2002.

01-038 Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries–Northern California

Project Officer: John Pilotte
Period: February 2001–January 2006
Funding: $150,000
Awardee: QMED

Status: Implementation began in early 2002.

01-222 Implementation Support for the Medicare Participating Centers of Excellence Demonstration

Project Officer: Raymond Wedgeworth
Period: September 2001–March 2005
Awardee: Barents Group
Funding: $379,991

Description: The purpose of this project is to assist CMS in the implementation of the Quality Partnerships Demonstration project. Under this demonstration, CMS selects premier cardiovascular and orthopedic programs and gives a bundled Part A & Part B payment (global payment) for all inpatient facility and physician services related to specific DRGs. Implementation support includes: 1) calculating the appropriate payment rates (both initial and annual updates); 2) developing the Office of Management and Budget (OMB) waiver cost estimate; 3) educating demonstration sites regarding payment calculations, 4) planning and implementing a pre-demonstration implementation conference, and 5) providing general technical support to CMS in carrying out the demonstration.

Status: This newly initiated project is in the startup phase.

01-112 Quality Monitoring for the Medicare Participating Center of Excellence Demonstration

Project Officer: Jody Blatt
Period: September 2001–December 2005
Awardee: Abt Associates
Funding: $735,160

Description: The purpose of the quality monitoring project is to develop a quality monitoring process that meets the general goals of various global payment demonstrations including the Medicare Partnerships for Quality Cardiovascular Services and Medicare Partnerships for Quality Total Joint Replacement Services ("Quality Partnerships" for short and formerly referred to as the "Medicare Participating Centers of Excellence Demonstration") and, subsequently, to coordinate and implement that process. The process incorporates the identification and technical definition of appropriate performance measures, collection of data in a centralized database, the development and distribution of reports to provide meaningful information back to demonstration participants and CMS, and coordination of the quality consortia meetings and conferences. The Quality Partnerships Demonstration involves bundled Part A & Part B payments to premier cardiovascular and orthopedic facilities for selected procedures. The selected cardiovascular and orthopedic procedures include coronary artery bypass surgery, cardiac valve procedures, angioplasty, and knee and hip replacements. We expect that the use of global payments will align the incentives for efficiency between the hospitals and the physicians, thereby enhancing not only the efficiency, but the clinical quality of services. All of the selected demonstration sites are invited to participate in a specialty-specific "quality consortia" that develops quality criteria and quantitative measures for monitoring performance during the demonstration.

Status: As of December 2001, the contractor is preparing to submit the required reports on performance measurement for cardiovascular and total

joint replacement procedures. They are also preparing a survey for demonstration sites regarding current system capabilities and relevant data collection activities. This contract will also be used to support other global payment and related demonstrations including the Provider Partnerships Demonstration and the New Jersey Hospital Association Demonstration. However, work related to these latter two demonstrations is on hold pending agency approval to proceed with implementation of the demonstrations.

02-051 Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration (Phase I and Phase II)

Project Officer: Victor McVicker
Period: September 2002–September 2007
Awardee: Research Triangle Institute, (DC)
Funding: $1,463,493

Description: The purpose of this project is to evaluate the Medicare Preferred Provider Organization (PPO) demonstration. A comprehensive evaluation will include 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 will be collected through site visits to participating plans and beneficiary surveys.

Status: Phase I (2002-2005), Phase II (2006-2007).

96-057 Case-Mix Adjustment for a National Home Health Prospective Payment System

Project Officer: Ann Meadow
Period: July 1996–May 2002
Awardee: Abt Associates
Funding: $3,955,955

Description: The primary focus of this study is to understand existing variation in home health resource patterns and to use this information to develop a case-mix adjuster for a national home health prospective payment system (PPS). Elements from the Outcome and Assessment Information Set (OASIS), which has been developed for quality improvement in Medicare home health agencies, are analyzed for their usefulness as measures within a case mix adjustment model. Additional detailed information, including information on resource utilization, has been collected from participating agencies. Ninety agencies were recruited and trained from eight States (Arkansas, California, Florida, Illinois, Massachusetts, Pennsylvania, Texas, Wisconsin) in the spring and summer of 1997. Data collection began in October 1997 and ended in the spring of 1999.

Status: The resulting case mix adjuster was incorporated in the Medicare home health PPS, which was implemented in October 2000. Selected OASIS items, collected at the start of each 60-day payment episode, are used for patient classification. An additional item on therapy utilization was added for purposes of the case mix model. The items fall into three major domains: clinical factors, functional-status factors, and utilization factors. Under modifications to the original contract, the project assumed additional tasks to 1) develop and test home health PPS grouper software, 2) provide technical assistance for setting PPS rates, 3) design and assist CMS in implementing an OASIS verification protocol for use by regional home health fiscal intermediaries, and 4) develop data and conduct analyses to refine the initial case mix model. Results of the study to date are available.

00-023 Direct and Indirect Effects of the Changes in Home Health Policy and an Analysis of the Skill Mix of Medicare Home Health Services Before and After the Balanced Budget Act of 1997

Project Officer: Sydney Galloway
Period: March 2000–September 2003
Awardee: Laguna Research Associates
Funding: $24,298

Description: This project provides partial support for a project primarily funded by the Robert Wood Johnson Foundation (RWJ). As part of this larger project, CMS supplies needed data and receives the results of a special study. The major (RWJ) project examines three areas where impacts of the Balanced Budget Act of 1997 (BBA) might fall: the Medicare beneficiary, home health care agencies, and the overall

medical and long-term care system. Analysis based on the data CMS supplies under this award, taken together, will help understand the overall pattern of impacts and be useful in formation of future reimbursement policy. The special study for CMS looks at beneficiary access. This will analyze patterns of Medicare home health use before and after the implementation of the BBA. There is a focus on assessing whether changes occurred in the skill mix of types of visits received by home health users. It will examine whether differential effects have occurred for different categories of home health users and in different geographic areas.

Status: The data are being accessed after considerable delay at CMS. They are being prepared for analysis as of December 2000. Because of this delay in access to the information, the project was extended through March 2002.

94-087 Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes

Project Officer: Ann Meadow
Period: September 1994–September 2002
Awardee: Center for Health Policy Research, University of Colorado
Funding: $1,496,245

Description: This study examines how to integrate home health care (HHC) with care in other settings to reduce overall health care costs. The central hypotheses of this study were that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most beneficial to patients, and that a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. A sample of patient records were analyzed from agencies in 20 States stratified into high, medium, and low-volume categories based on annual visits per beneficiary, and patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode was recorded. Long-term, self-reported outcomes were measured from telephone interview data at HHC admission and from 6-month followups. These primary data concerning patient status and outcomes were combined with Medicare claims data over the episode of care to study the relationship between service volume in HHC and both patient outcomes and costs.

Status: Four common conditions (congestive heart failure, stroke, surgical hip procedures, and open wounds) were studied. Two-sample tests for mean differences in case mix characteristics and volume were performed to compare the two volume groups within each condition. The median volume (defined as number of visits until discharge or first inpatient admission) differed by a factor of about four to nine, depending on the condition. For home health aide services, mean volume differed by a factor of between 30 and 47. Limitations in activities of daily living (ADLs) were significantly greater for the high-volume groups, these patients had a greater prevalence of chronic conditions, and their institutional utilization within the 14 days prior to admission was less likely to be an acute-care hospital, indicating the more post-acute nature of the low-volume groups. This general case mix difference is consistent with the greater use of aide services for high-volume patients. Preliminary analyses of outcomes suggested relatively few differences in outcomes by volume, after controlling for condition. This result may mean that the additional services delivered to the high-volume group helped equalize outcomes between more severely ill and less severely ill patients.

01-233 Studies in Home Health Case Mix

Project Officer: Ann Meadow
Period: September 2001–December 2005
Awardee: Abt Associates
Funding: $739,713

Description: The purpose of this project is to further develop the case mix model used for the home health PPS system implemented in October 2000, and to explore new approaches to case mix adjuster development. Some of the results may have near- or medium-term application to CMS rulemaking for Medicare home health payment because they are

essentially extensions of the current model. Other results are not necessarily extensions of the current model and, therefore, might find application in the longer-term future. All work will be conducted using existing administrative databases.

Status: The project is in the early developmental stages.

99-057 Evaluation of Issues Related to Prospective Payment System under Consolidated Bidding for Skilled Nursing Facilities and Home Health Agencies

Project Officer: Cindy Murphy
Period: August 1999–June 2003
Awardee: Jing Xing Technologies
Funding: $938,370

Description: This project provides analytical support for CMS on operating issues (claims processing, medical review (MR) and data processing) for providers and contractors (intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERC)) related to implementation of skilled nursing facility (SNF) Part A prospective payment system (PPS) consolidated billing under Parts A and B, and implementation of the new SNF Part B fee schedule.

Status: The report is available.

00-090 Behavior Validation to Decrease Problem Behaviors of Elderly with Advanced Dementia

Project Officer: Dennis Nugent
Period: September 2000–January 2002
Awardee: University of Missouri - Kansas City, Office of Research Administration
Funding: $250,000

Description: This project studies the effect of using behavior validation strategies to manage problem behaviors of nursing home elderly with dementia of the Alzheimer's type (DAT). The objectives are to determine if a program of behavior validation, used by nursing home caregivers, will decrease residents' behavior problems, and to explore the feasibility of integrating this program into orientation and staff education. The usual course of DAT disease progression is associated with problem behaviors (disruptive, inappropriate, and agitated), which occur in 20-90 percent of nursing home residents depending on the level of dementia. These behaviors are expensive in that they cause harm to staff and other residents; increase the use of chemical and physical restraints; increase staff dissatisfaction, absenteeism and turnover rates; and can even result in property damage. While some behavior management interventions have been shown to be effective, they are underutilized. Behavior validation consists of verbal and nonverbal responses to a behavior problem to calm the resident and redirect the behavior into one that is more favorable. Behavior education for staff addresses characteristics of problem behaviors and actions that are effective in behavior management.

Status: The project is complete and the final report is being drafted. The Principal Investigator has indicated that the report will be ready at the end of the award period.

97-005 Rebasing Prospective Payment System and Exempt Hospital & Skilled Nursing Facility Input Price Indices from Newly Available Sources

Project Officer: Stephen Heffler
Period: February 1997–September 2002
Awardee: Jing Xing Technologies
Funding: $592,265

Description: This project assists in the rebasing of the prospective payment system (PPS) and exempt hospital input price indexes, and the skilled nursing facility (SNF) input price indices using data from newly available sources. It will also assist in the study of the relationships between different health care payers in different health care settings and a determination of alternative methodologies for updating Medicare payments using prices, productivity, technology, and demographics. For the National Health Accounts, it will assist in the development of a time series of annual capital expenditures of fixed and movable equipment and a time series of annual expenditures for nursing home care and home health care in hospital-based

nursing facilities and hospital-based home health agencies (HHAs).

Status: Most tasks have been completed, including rebasing the PPS and SNF input price indexes, estimating hospital-based SNF and HHA expenditures, reviewing alternative update methodologies, and using the Medicare cost reports to estimate hospital payments and expenditures. Work is completed on estimating capital expenditures for the National Health Accounts.

00-067 Medicare Post-Acute Care: Evaluation of Balanced Budget Act Payment Policies and Related Changes

Project Officer: Philip Cotterill
Period: September 2000–September 2002
Awardee: MEDSTAT Group (DC)
Funding: $636,557

Description: The purpose of this project is to study the impact of Balanced Budget Act (BBA) and other policy changes on Medicare utilization and delivery patterns of post-acute care. Post-acute care is generally defined to include the Medicare covered services provided by skilled nursing facilities (SNFs), home health agencies, rehabilitation hospitals and distinct part units, long-term care hospitals, and outpatient rehabilitation providers. This initial project will compare changes between the pre-BBA period of the 1990's and the post-BBA year, 1999. The study will include a variety of beneficiary, provider, and market area analyses. Since the impacts of policy changes not yet implemented will continue to be of interest for many years, the analyses developed under this contract are expected to use and refine methods that can be applied in future evaluation research.

Status: Much of the first year of the project was spent constructing data sets.

00-094 Study of the Impact of Boren Amendment Repeal on Nursing Facility Services for Medicaid Eligibles

Project Officer: Paul Boben
Period: September 2000–March 2002
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $268,875

Description: The purpose of this project is to study the impact of the repeal of the Boren Amendment on Medicaid beneficiaries' access to care in a nursing facility (NF), a hospital, or intermediate care facility for the mentally retarded (ICF/MR) and the quality of care available to them in those facilities. The study will examine rate setting methodologies to learn whether States have changed their methods of payment since the repeal of the Boren Amendment and whether these changes have affected access to care or quality of care received by Medicaid beneficiaries.

Status: In July 2001, the contract was modified to incorporate analyses of the impact of repeal of the Boren Amendment on hospitals and ICF/MR, in addition to the existing study focusing on NF. The period of performance was extended to March 30, 2002 to accommodate the additional work. A draft Report to Congress on the impact of Boren Amendment repeal on access to and quality of NF services was received in February 2001. Draft reports on hospitals and ICF/MR are expected by January 2002, and will be submitted to Congress as a follow-up report. A report of a multivariate analysis of the effect of Medicaid payment policies on the NF sector is also expected in 2002.

01-108 Assessment, Refinement and Analysis of the Existing Prospective Payment System for Skilled Nursing Facilities

Project Officer: Carolyn Rimes
Period: July 2001–July 2005
Awardee: Urban Institute
Funding: $6,383,566

Description: This project supports CMS in 1) the assessment of the feasibility of refining the current Medicare payment system for skilled nursing facilities and, if feasible, produce analyses that support these refinements and 2) our exploration of different systems for categorizing patients and their resource allocation. It will analyze data and prepare a report containing recommendations for possible revisions to the classification of patients in a manner that accounts for the relative resource use of different patient types. This project focuses only on the Medicare beneficiary population, including those beneficiaries defined as dually eligible.

Status: Phase I focuses on the design and creation of a data base. Phase II analyses support annual refinements to the payment system and analysis, testing, simulations, and making recommendations regarding potential options for modifying, restructuring, or reconfiguring the existing patient classification and payment system for skilled nursing facilities.

98-239 Evaluation of Competitive Bidding Demonstration for DME and POS

Project Officer: Ann Meadow
Period: September 1998–May 2003
Awardee: University of Wisconsin - Madison
Funding: $2,315,249

Description: CMS has mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics, and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use marketplace competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the current project is being conducted under that authority. The initial site of the demonstration is Polk County, Florida. A second site, San Antonio, Texas, was selected in 2000. Competitively bid product categories in Polk are oxygen supplies and equipment, hospital beds, enteral nutrition, surgical dressings, and urological supplies. Product categories in Texas are oxygen supplies and equipment, hospital beds, manual wheelchairs, nebulizer drugs, and non-customized orthotics. Medicare contracts with winning suppliers in Polk County commenced in October 1999, and San Antonio contracts commenced in February 2001.

Status: A pre-demonstration survey of oxygen users and users of other medical supplies was fielded in two Florida counties (Polk and Brevard) in March 1999. The results suggested beneficiaries were highly satisfied with the services and products delivered by their Medicare suppliers. A followup survey, fielded in CY 2000, will provide data for the pre-test/post-test comparison design analyzing the impact of the demonstration in Polk County. The evaluation team conducted five site visits to Polk County in 1999 and 2000 as part of the project's case study activities addressing access, quality, and administrative and market outcomes. A baseline survey in two Texas areas, San Antonio and Austin-San Marcos, was fielded in 2000, and an initial site visit to Texas was conducted in late 2000. Other evaluation activities include claims analyses, focus groups, fee-schedule analyses, and additional surveys. The first annual evaluation report to Congress is scheduled for release in early CY 2001. A paper analyzing the responses to the Polk County baseline survey has been submitted for publication.

98-252 Evaluating the Use of Quality Indicators in the Long Term Care (LTC) Survey Process

Project Officer: Lisa Hines
Period: September 1998–September 2003
Awardee: Research Triangle Institute, (NC)
Funding: $3,934,228

Description: This project will evaluate how to integrate quality indicators into the regulatory process. Quality indicators could be used for monitoring and assessing facility performance in numerous domains and supporting appropriate corrective and enforcement actions. This task order will develop and test various options for using a variety of quality indicators to improve the effectiveness and efficiency of CMS' monitoring of facility performance.

Status: The project team is currently testing the computerized system in field tests. An alpha test of the system is planned for spring 2002 using CMS and State Survey team staff. Development and incorporation of investigative protocols will occur through the summer of 2002. Beta testing of the completed system is planned for Fall 2002.

94-131 Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses

Project Officer:	Tamara Jackson-Douglas
Period:	September 1994–December 2002
Awardee:	Monroe County Long Term Care Program, Inc.
Funding:	$96,498

Description: This demonstration project was designed to determine the cost and effectiveness of providing consumer-directed care on the health status, quality of life, cost, and service use of community-dwelling Medicare beneficiaries who are chronically ill, functionally impaired, and at high risk for repeated hospital admissions. The demonstration uses three treatment models to test how well different models of care empower and inform the patient to make decisions on health care that are more cost-effective and lead to improved or sustained health outcomes. Outcomes are measured by hospital utilization; total health and long-term care costs; health and functional status; problematic behaviors; quality of life; caregiver stress and burden; and patient, caregiver, and physician satisfaction. This demonstration is located in two geographic areas: Monroe County, New York, and the mid-Ohio valley, which includes portions of northern West Virginia and southern Ohio.

Status: The project was originally approved in 1994; however, waivers were not approved for the three intervention groups until April 1997 due to the lengthy process of defining and re-defining the design of the demonstration. Although sites began enrolling patients in late 1996, enrollment did not begin in earnest until after the final waiver approval was secured, and full enrollment of the required 1600 chronically ill Medicare beneficiaries was not achieved until June 2000. Based on the 24-month treatment period, the last enrollees are to receive service through June 2002. Funding for the project concludes in December 2002, after six months of phase-down activities for the investigator teams, including final data analysis and report generation.

This project was granted several extensions in the past to account for delays associated with startup. In late 2001, the project's principal investigators requested an additional 12 months of waivered services and an additional $1.5 million to complete their evaluation. Their request was not approved.

Consumer Directed Durable Medical Equipment Demonstrations

These demonstrations support the United States Department of Education's "Center for Independent Living" projects. A Center for Independent Living is a local consumer-led organization devoted to helping people with disabilities live and work within their communities. This CMS demonstration effort helps Medicare beneficiaries with disabilities exercise greater choice and control in meeting their personal needs for wheelchairs and other durable medical equipment. Goals of the projects include treating individuals with disabilities with dignity, providing the necessary tools to live and work more independently, and assisting people with disabilities to be successfully employed. CMS and the Department of Education will share any innovations and best practices identified under the demonstration projects.

00-050 Consumer Directed Durable Medical Equipment Demonstration Project

Project Officer:	Paul Mendelsohn
Period:	September 2000–August 2004
Awardee:	Ability Resources Inc.
Funding:	$150,000

Status: As of the fall of 2000 this project was in the early stages.

00-049 Consumer Driven Durable Medical Equipment Acquisition Program

Project Officer: Paul Mendelsohn
Period: September 2000–August 2004
Awardee: Center for Independent Living of Southwest Pennsylvania
Funding: $150,000

Status: As of the fall of 2000 this project was in the early stages.

00-051 Consumer Directed Durable Medical Equipment Demonstration for Beneficiaries with Disabilities

Project Officer: Paul Mendelsohn
Period: September 2000–August 2004
Awardee: Center for Living and Working
Funding: $150,000

Status: As of the fall of 2000 this project was in the early stages.

01-286 Medicare Competitive Bidding Demonstration for Durable Medical Equipment, II

Project Officer: Mark Wynn
Period: August 2001–September 2002
Awardee: Palmetto Government Benefits Administrators
Funding: $715,000

Description: This demonstration project is being implemented to test the feasibility of obtaining lower prices through competitive bidding for selected lines of durable medical equipment, prosthetics, orthotics, and supplies. Suppliers selected as demonstration suppliers are the only ones eligible to receive Medicare payments for supplying the products covered by the demonstration. Demonstrations are being implemented in two metropolitan areas–Polk County, Florida and the San Antonio, Texas Metropolitan Statistical Area (MSA). The supply lines that were offered for competitive bidding at the Florida site are: 1) home oxygen therapy; 2) hospital beds and accessories 3) enteral nutrition therapy; 4) surgical dressings 5) and 6) urological supplies. The supply lines that were offered for competitive bidding at the Texas site are: 1) hospital beds and accessories, 2) home oxygen therapy, 3) manual wheelchairs and accessories, 4) noncustomized orthotics, and 5) nebulizer inhalation drugs.

Status: The first demonstration site became operational in October 1999 in Polk County Florida. Sixteen suppliers were selected as "Demonstration Suppliers" for one or more of the covered product categories. The new rates took effect in October 1999 and remained in effect for 2 years. A second round of bidding took place in Polk County in 2001 to determine the prices for the final year of the project. The second demonstration site became operational in February 2001 in the San Antonio, Texas MSA. The new rates took effect in February 2001 and will remain in effect through 2002. The average savings at the two demonstration locations was 20 percent, as compared with the Medicare fee schedule.

00-052 Consumer Directed Durable Medical Equipment Demonstration for People with Physical Disabilities

Project Officer: Paul Mendelsohn
Period: September 2000–August 2004
Awardee: Alpha One Center for Independent Living
Funding: $150,000

Status: As of the fall of 2000 this project was in the early stages.

99-081 Developing and Evaluating the Use of a Quality Indicator Format in the End Stage Renal Disease Survey Process

Project Officer: Judith Kari
Period: September 1999–June 2003
Awardee: Lewin Group
Funding: $466,231

Description: The purpose of this project is to develop, test, and describe improved processes and formats for enhancing the survey process for End Stage Renal

Disease (ESRD) facilities. An improved survey process would include effectively using quality indicators in the survey process, developing more consistent and accurate survey results, and developing more efficient and objective ways to record survey results.

Status: The progress on this project has been suspended since February 2000.

New York Graduate Medical Education Demonstration

This demonstration provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. The project was expected, overall, to reduce the number of residents and costs to the program. Concerns were that such a reduction would impact access and service delivery as well as having economic and workforce effects.

97-232 New York Graduate Medical Education Demonstration: Woodhull Medical and Mental Health Center

Project Officer: Sidd Mazumdar
Period: February 1997–March 2002
Awardee: Woodhull Medical and Mental Health Center
Funding: $0

Description: This site was a participant in a major demonstration that provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. This project also spoke to several provisions of the Balanced Budget Act of 1997 (BBA), which were also aimed at reducing annual graduate medical education (GME) spending. Medicare's annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The project was expected, overall, to reduce the number of residents and, thus, costs to the program. Concerns were that such a reduction would impact access and service delivery as well as have economic and workforce effects.

Status: Woodhull Medical and Mental Health Center withdrew in 2002.

97-261 New York Graduate Medical Education Demonstration: New York Eye and Ear Infirmary

Project Officer: Sidd Mazumdar
Period: February 1997–March 2002
Awardee: New York Hospital & Presbyterial Hospital
Funding: $0

Status: New York Eye and Ear Infirmary withdrew in 2002.

97-260 New York Graduate Medical Education Demonstration: Metropolitan Hospital Center

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Metropolitan Hospital Center
Funding: $0

Status: Metropolitan Hospital Center remains in the demonstration.

97-256 New York Graduate Medical Education Demonstration: Harlem Hospital Center

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Harlem Hospital Center
Funding: $0

Status: Harlem Hospital Center remains in the demonstration.

97-254 New York Graduate Medical Education Demonstration: Westchester Medical Center, Sound Shore Medical Center & Mount Vernon Hospital Joint Project

Project Officer: Sidd Mazumdar
Period: February 1997–February 2002
Awardee: Westchester Medical Center
Funding: $0

Description: This site was a participant in a major demonstration that provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. This project also spoke to several provisions of the Balanced Budget Act of 1997 (BBA) that were also aimed at reducing annual graduate medical education (GME) spending. Medicare's annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The project was expected, overall, to reduce the number of residents and thus costs to the program.

Status: This was a joint project with Sound Shore Medical Center & Mount Vernon Hospital; however, Westchester and Sound Shore withdrew in March 1999. Only Mount Vernon Hospital remained as of 2002.

97-252 New York Graduate Medical Education Demonstration: Jacobi Medical Center & North Central Bronx Hospital Joint Project

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Jacobi Medical Center
Funding: $0

Description: A joint project of Jacobi Medical Center & North Central Bronx Hospital.

Status: This site was a participant in a major demonstration that provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. This project also spoke to several provisions of the Balanced Budget Act of 1997 (BBA), which were also aimed at reducing annual graduate medical education (GME) spending. Medicare's annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The project was expected, overall, to reduce the number of residents and, thus, costs to the program.

97-250 New York Graduate Medical Education Demonstration: Mount Sinai Consortium

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Mount Sinai Medical Center
Funding: $0

Description: Consortium Members: Cabrini Medical Center, Elmhurst Hospital Center, Mount Sinai Medical Center, and Queens Hospital Center.

Status: This site was a participant in a major demonstration that provided incentives for New York State teaching hospitals to reduce their graduate medical residencies by 20 to 25 percent over a 5-year period. This project also spoke to several provisions of the Balanced Budget Act of 1997 (BBA) that were also aimed at reducing annual graduate medical education (GME) spending. Medicare's annual GME spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. The project was expected, overall, to reduce the number of residents and thus costs to the program. Concerns were that such a reduction would impact access and service delivery as well as having economic and workforce effects. Cabrini, Elmhurst, and Mount Sinai withdrew as of March 10, 1999. Only Queens Hospital Center remains in the demonstration.

97-253 New York Graduate Medical Education Demonstration: Maimonides Medical, Coney Island Hospital & Interfaith Medical Center Joint Project

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Maimonides Medical Center
Funding: $0

Status: This was a joint project with Coney Island Hospital & Interfaith Medical Center; however, only Interfaith Medical Center remains in the demonstration. Coney Island withdrew in June 1999.

97-240 New York Graduate Medical Education Demonstration: Bronx-Lebanon Hospital Center

Project Officer: Sidd Mazumdar
Period: February 1997–March 2002
Awardee: Bronx-Lebanon Hospital Center
Funding: $0

Status: Bronx-Lebanon Hospital Center withdrew in 2002.

97-239 New York Graduate Medical Education Demonstration: Lincoln Medical and Mental Health Center

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: Lincoln Medical and Mental Health Center
Funding: $0

Status: Lincoln Medical and Mental Health Center remains in the program.

97-251 New York Graduate Medical Education Demonstration: New York University Consortium

Project Officer: Sidd Mazumdar
Period: February 1997–June 2003
Awardee: New York University Medical Center
Funding: $0

Status: Consortium Members: Bellevue Hospital Center, Brooklyn Hospital Center, Hospital for Joint Diseases, Lenox Hill Hospital, New York University Downtown Hospital, and New York University Medical Center.

99-054 Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions

Project Officer: William Buczko
Period: September 1999–September 2004
Awardee: Health Economics Research
Funding: $1,692,751

Status: "Recommended Design and Strategy for NY GME Demonstration and National BBA GME Provisions" is available from the National Technical Information Service, accession number PB99-175063. There are a series of reports available, including a summary report on the New York GME demonstration during the period from July 1997 through June 2000.

00-022 Rationalize Graduate Medical Education Funding

Project Officer: Sidd Mazumdar
Period: February 2000–September 2005
Awardee: Medical Education Council
Funding: $839,875

Description: Since 1997, CMS has been working with the State of Utah on a project that will pay Medicare direct and indirect graduate medical education (GME) funds ordinarily received by the State's hospitals to the State of Utah Medical Education Council. GME funds will be distributed to training sites and programs according to the Council's research on workforce needs.

Status: Approval of waivers for the demonstration is needed to begin implementation.

99-030 Programming and Data Base Support for Examining Physician Opt-out Access Issues

Project Officer: William Buczko
Period: May 1999–July 2002
Awardee: CHD Research Associates
Funding: $59,079

Description: This project involves the creation of data files and production of descriptive statistics for Part B claims for calendar years 1997 and 1998 for Medicare beneficiaries who had been treated in 1997 by physicians who opted out of Medicare in 1998 and for calendar years 1998 and 1999 for beneficiaries treated by physicians opting out during 1999. The analysis of these data will assist CMS in evaluating whether beneficiaries who had been patients of opt-out physicians were able to find other physicians to continue their care. The Balanced Budget Act of 1997 permitted physicians and some nonphysician providers to opt out of the Medicare program. Under the legislative provisions for opting out, physicians providing their carriers with affidavits stating their desire to opt out of Medicare could withdraw from the program for a 2-year period. These physicians would then treat beneficiaries under private contracts.

Status: Descriptive utilization tables have been run for beneficiaries treated by the cohort of providers opting out during 1998. Utilization trends are broken out by age, sex, race, State of residence, physician specialty and Berenson-Eggers Type of Service code. Extracts of all Medicare Part B records for patients of 1999 opt-out physicians have been created. Descriptive tables for this cohort were constructed in July 2002.

99-042 Validation of Physician Time Data

Project Officer: Jim Menas
Period: August 1999–March 2002
Awardee: Health Economics Research
Funding: $460,668

Description: The project focused on the validity of the current time estimates for certain high volume codes paid under the Medicare Physician Fee Schedule. One of the tasks developed alternative sets of services for validation. The project evaluated alternative sets of criteria, including high volume, high volume per specialty, low absolute time estimates, and reference set services. It also constructed time estimates for codes using three different secondary data sets. The three data sources on which analyses were conducted were the Medical Group Management's Profiling Data Base, D. J. Sullivan Operative Time Data Base, and National Ambulatory Medical Care Survey (NAMCS).

Status: The final report on the NAMCS data and the D.J. Sullivan Operative Time Database are available from the CMS Web site as of January 2002. A second report on MGMA's Profiling Database and additional selected codes from the D.J. Sullivan Database was completed in March 2002.

99-045 Study of Medicare Payments in Health Professional Shortage Areas

Project Officer: William Buczko
Period: September 1999–May 2002
Awardee: RAND Corporation
Funding: $327,326

Description: This project compiles data on trends in Medicare service utilization and payments in rural areas, Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) over the past decade. It examines the distribution of Medicare payments to HPSAs/MUAs for services provided in, or to residents of, these areas. This project will also assess the adequacy of these geographic designations and special payments and examine possible geographic designation and Medicare rural payment policy reforms.

Status: Analyses of substitution of Rural Health Center visits for physician office visits, the relationship between primary care services and avoidable hospitalizations, and alternative methods for classifying rurality and the project final report were due May 2002.

00-116 Design, Development, and Implementation of an Improved Medicare Outpatient End Stage Renal Disease Prospective Payment System

Project Officer: William Cymer
Period: September 2000–March 2002
Awardee: Michigan Public Health Institute
Funding: $380,038

Description: This project is the first phase of a research effort to design, develop, test, and aid in the implementation of an improved Medicare outpatient end stage renal disease prospective payment system

(ESRD PPS). This phase will identify, describe, and evaluate the adequacy of relevant CMS databases for the development of a bundled outpatient ESRD PPS. In a bundled PPS, all outpatient renal related services, tests, drugs, and supplies would be incorporated into a fixed reliable payment rate. Differences in patient specific case-mix that can be associated with legitimate differences in resource consumption would be reflected in differences in payment. This study is necessary to determine whether a case-mix measure might be appropriate under a bundled outpatient ESRD PPS.

Status: Based on findings from this first phase of research, the project assesses whether CMS databases permit the construction of clinically and statistically coherent case-mix measures predictive of provider differences in Medicare costs in a bundled outpatient ESRD PPS.

99-032 Practice Expense Methodology

Project Officer: Ken Marsalek
Period: May 1999–May 2004
Awardee: Lewin Group
Funding: $374,953

Description: This project provided technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule.

Status: An evaluation of the 1998 questionnaire and an initial review of the methodology of the practice expense per hour values derived from the data was completed. Recommendations regarding the practice survey design and methodology and considering how the practice-level survey could be used and how the information could be cross-walked to the socioeconomic monitoring system survey are available. In addition, medical specialty organizations reviewed and made recommendations.

99-034 Describing and Assessing the Implication of Developing and Implementing a Prospective Payment System for Long Term Care Hospitals

Project Officer: Carolyn Rimes
Period: June 1999–March 2002
Awardee: Urban Institute
Funding: $1,805,764

Description: This project evaluates a Prospective Payment System for Long Term Care Hospitals (PPS) and has provided analyses in support of Part B Therapy Services under Medicare. The project involves the construction of a database describing and analyzing the universe of long-term care hospitals (including any units subsequently defined/certified or licensed as long-term care hospitals) in terms of: facility characteristics, beneficiary use, beneficiary characteristics including diagnoses, referral, transfer and discharge patterns and relationship of these facilities with acute care and other care providers, including skilled nursing facilities, home health agencies and rehabilitation hospitals. Information from the database will be used to describe and analyze the long-term care hospitals and their interrelationship with other components of the health care system. Discharge diagnoses from long-term care and acute-care hospitals, including a detailed analysis of the treatment patterns for patients; International Classification of Diseases, 9th Revision, Clinical Modification codes; and age, gender, and disposition codes, including principal and additional diagnoses and procedural codes, will be analyzed.

Status: Analyses on the long term care hospitals has been completed. The work assessing the relationship between the outpatient therapies, specifically the impact of extending fee schedule payments and coverage limits, has been completed and is available. Additional analyses on Part B therapy services under Medicare is ongoing. The analysis on home heath is ongoing.

99-038 Design, Development, Implementation, Monitoring & Refinement of a Prospective Payment System for Inpatient Rehabilitation

Project Officer: Carolyn Rimes
Period: July 1999–September 2004
Awardee: RAND Corporation
Funding: $5,908,651

Description: The purpose of this project is to support the design and develop, implement, monitor, and refine a case-based prospective payment system for rehabilitation facilities providing services to Medicare beneficiaries. Phase I of this project has been completed. This research has supported the development of a PPS for inpatient rehabilitation. This included the assessment and development of a classification system based upon both UDSmr and MEDIRISK data and focused on the Medicare population. The project will assess the feasibility of including or considering additional MDS PAC variables, and assess the potential impact of the FIM-FRG classification system and subsequent payment system.

Phase II of this contract will be creating a national data base merging the Inpatient Rehabilitation Facility Patient Assessment Instrument with CMS administrative data to analyze the case mix groups and the facility adjustments for refinements to the payments systems, as well as analysis of special cases i.e., day and cost outliers, short stay, deaths, transfers and interrupted stay. Phase II will create and assist CMS in developing a monitoring system to assess the impact of the inpatient PPS and analyze the results of the staff time measurement study to assess compression. Additional tasks that will be addressed in the second phase of this contract include: impact of specific departments within the facilities or exempt units, assessment of technological innovations' impact on functional groups or the payment system, analysis of ADLs to predict disability status and payment, and continued analysis of the impact of motor and cognitive variables on predicting disability status and payment. This phase will continue to analyze the impact of impairment groups, with and without comorbidities, and analyze the impact of comorbidities and their relationship to RICs and complexities.

Status: A work plan and interim report on "Inpatient Rehabilitation Facility Prospective Payment System" for Phase I is available. The Phase II work plan is under review.

99-062 Hospital Outpatient Prospective Payment System: Development of Volume Performance Standards and a Hospital Outpatient Market Basket

Project Officer: Barbara Lutz
Period: September 1999–January 2002
Awardee: Health Economics Research
Funding: $410,303

Description: This project helped CMS construct a market basket specific to hospital outpatient services so that the market basket can be used to annually update the payment rates for outpatient services under the prospective payment system (PPS), including partial hospitalization services in Community Mental Health Centers (CMHCs). The project helped determine a feasible long-term methodology for controlling unnecessary volume increases in hospital outpatient services and in partial hospitalization services furnished in CMHCs paid under the hospital outpatient PPS. With the exception of ambulance and outpatient rehabilitation services, which are subject to separate fee schedules, the law provides the authority to determine which services are included under the hospital outpatient PPS.

Status: This project was completed.

97-201 Municipal Health Services Program: Baltimore

Project Officer: Ronald Deacon
Period: June 1978–December 2004
Awardee: City of Baltimore
Funding: $0

Description: This project is part of the Municipal Health Services Program (MHSP), a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the

effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress extended the demonstration several times. The Balanced Budget Act of 1997 extended the demonstration until December 31, 2000. It also mandated a transition plan limiting any new enrollment and providing a smooth transition from demonstration to non-demonstration status. The Balanced Budget Refinement Act of 1999 extended the transition phase until December 31, 2002, and the Benefits Improvement and Protection Act of 2000 again extended it until December 2004. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

97-204 Municipal Health Services Program: Cincinnati

Project Officer: Ronald Deacon
Period: June 1978–December 2004
Awardee: Center for Health Policy Research, University of Colorado
Funding: $0

Description: This project supports the Municipal Health Services Program (MHSP), a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress extended the demonstration several times. The Balanced Budget Act of 1997 extended the demonstration until December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the transition phase until December 31, 2002, and the Benefits Improvement and Protection Act of 2000 again extended it until December 2004. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

97-203 Municipal Health Services Program: Milwaukee

Project Officer: Ronald Deacon
Period: June 1978–December 2004
Awardee: City of Milwaukee
Funding: $0

Description: This project is part of the Municipal Health Services Program (MHSP), a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress extended the demonstration several times. The Balanced Budget Act of 1997 extended the demonstration until December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the

transition phase until December 31, 2002, and the Benefits Improvement and Protection Act of 2000 again extended it until December 2004. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

97-202 **Municipal Health Services Program: San Jose**

Project Officer: Ronald Deacon
Period: June 1978–December 2004
Awardee: City of San Jose
Funding: $0

Description: This project is part of the Municipal Health Services Program (MHSP), a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and CMS. CMS provides Medicare and Medicaid waivers to test the effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care. Waivers and grants were awarded to Baltimore, Cincinnati, Milwaukee, and San Jose in June 1978.

Status: Congress extended the demonstration several times. The Balanced Budget Act of 1997 extended the demonstration until December 31, 2000. The Balanced Budget Refinement Act of 1999 extended the transition phase until December 31, 2002, and the Benefits Improvement and Protection Act of 2000 again extended it until December 2004. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

01-279 **Consultation and Assistance with Evaluation of the Medigap Monitoring Demonstration Grants**

Project Officer: Marcia Marshall
Period: September 2001–December 2002
Awardee: L. Sue Anderson
Funding: $19,850

Description: This project provides support to intramural staff to evaluate the results of the Medigap Monitoring Demonstration Grants projects being awarded in fiscal year 2001. These demonstrations collect information, monitor, and report on market conduct and violations by issuers of Medicare supplemental insurance–Medigap Insurance. The project will work with the Medigap Monitoring grant project officer to review reporting requirements and determine a process and methodology to proceed with reporting on the activities of the demonstrations, and to facilitate evaluation. It will also process and summarize the demonstration grant reports and the 3-, 6- and 9-month marks. Finally, it will evaluate the effectiveness of each of the demonstrations and compare each to the others for a final evaluation.

Status: The project is newly underway.

99-048 **Design and Simulation of Alternative Medigap Structure**

Project Officer: John Robst
Period: September 1999–February 2002
Awardee: Lewin Group
Funding: $588,984

Description: The project compiled premium data on existing standard Medigap premiums, formulated alternative standard benefit packages, and estimated premium costs of these alternative packages. From this analysis, the current and alternative Medigap options were compared. Despite many changes in the Medicare program since the early 1990s, the basic benefit structure of Medicare supplemental insurance has remained unchanged. This project examined possible

updated Medigap benefit structures and compared these alternatives to the premiums and benefit structures of currently available supplementary coverage, as well as Medicare+Choice options.

Status: Collection of existing standard Medigap premiums from insurance carriers and State insurance commissioners is nearing completion.

00-118 Retiree Health Benefits

Project Officer: Brigid Goody
Period: September 2000–June 2002
Awardee: University of Wisconsin - Madison
Funding: $249,971

Description: This project examines current employer-based health insurance coverage for Medicare-eligible retirees, the prospects for continuation of this coverage, and possible implications for the restructuring of the Medicare fee-for-service (FFS) and Medicare+Choice (M+C) programs. Although approximately one-third of aged Medicare beneficiaries have coverage under an existing employer-sponsored health insurance policy, the prevalence of coverage has declined and retiree cost-sharing requirements have increased in recent years. The project will consist of two parts. The first part will analyze existing secondary data to describe the types of coverage offered to Medicare-eligible retirees, the funding for this coverage, and recent trends in coverage. The second part will be comprised of interviews aimed at understanding the prospects for future employer-sponsored coverage of this population, possible impacts of Medicare reform initiatives on this coverage, and how the Medicare program, both FFS and managed care, might be restructured to encourage continued coverage.

Status: The contractor has completed the first phase of the study and submitted a draft interim report. The interim report presents their analysis of the Kaiser Family Foundation/Health Research and Education Trust and the Medicare Current Beneficiary surveys. Key findings include:

- Availability of retiree health coverage has been fairly constant in recent years.
- There are differences in subgroups of beneficiaries with and without retiree coverage. White non-Hispanic beneficiaries with higher education and income, and who are married, are significantly more likely to have employer-sponsored insurance.
- In contrast to active employees, indemnity plans still constitute the dominant source of insurance coverage for retirees.
- Nearly all retiree health plans provide some form of prescription drug coverage.
- Only a small percentage of employers are considering changes to their retiree health benefits.

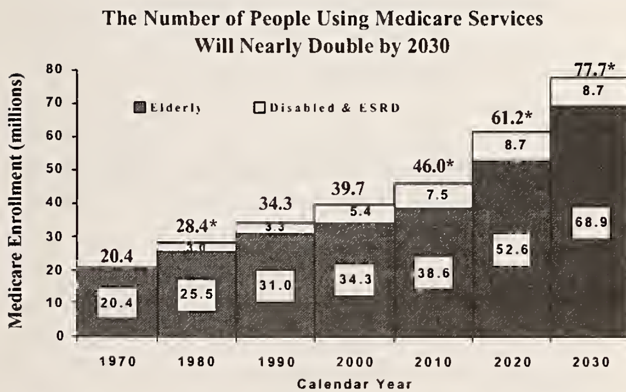
02-063 Evaluation of Wheel Chair Purchasing in the Consumer-Directed Durable Medical Equipment (CD-DME) Demonstration and Other Fee-For-Service and Managed Care Settings

Project Officer: William Clark
Period: September 2002–September 2004
Awardee: Abt Associates
Funding: $294,852

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. 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.

Theme 4: Future Trends Influencing Our Programs

CMS performs environmental scanning, identifying, evaluating, and reporting emerging trends in health care delivery and financing, and their interactions with Agency programs. Our research and evaluation projects study the effect on beneficiaries, providers, plans, States and other partners and customers. Projects are designed to assess potential improvements and develop new measurement tools. For example, we identify trends in health care delivery and assess the impact of long-term structural reforms necessary to address major demographic changes in the beneficiary population. Specific projects in this area include examining the demographics of future Medicare beneficiaries and considering the effect of "healthy aging;" assessing the effect on quality of life, health and services as beneficiaries move into "deinstitutionalized" settings; assessing long term growth assumptions for health expenditures, identifying the impacts of possible eligibility changes and of potential changes in health status, technology, and the marketplace; examining prescription drug expenditures and savings from alternative reimbursement policies based on different discount rate and price schedules used by other payers, and testing the use of purchasing polices including competitive bidding and rebate mechanisms; analyzing various potential changes in the benefit package; and examining how our payment systems affect adoption of new technology.



**The total number of beneficiaries may not equal the sum of the two categories due to rounding.*
Source: *CMS, Office of the Actuary.*

01-148 Costs for Providing Health Care to Undocumented Persons

Project Officer: Arthur Meltzer
Period: September 2001–September 2002
Awardee: United States/Mexico Border Counties Coalition
Funding: $300,000

Description: This project will estimate the costs in public, private and not-for-profit hospitals in the 24 U.S. counties bordering Mexico that provide emergency medical care and transportation services to undocumented persons who do not qualify for Medicaid. Innovative policies that may lower the cost to treat undocumented persons and survey the types of emergency medical care provided by hospitals and emergency transportation carriers to undocumented persons will be identified. This project may be limited to a descriptive analysis using existing data sources of the provision of emergency care in the undocumented alien population and a thorough review of the existing literature, laws and policies pertaining to this subject.

Status: This newly initiated project is in the startup phase.

01-213 Market Area Selection Criteria and Data Development for Medicare Fee-for-Service Reform

Project Officer: David Skellan
Period: September 2001–September 2002
Awardee: Research Triangle Institute, (NC)
Funding: $233,887

Description: This project will provide a foundation for a centralized system of collecting and maintaining market area characteristics and information that is needed to better understand market conditions that are crucial in targeting these new initiatives to ultimately assure that Medicare beneficiaries and the program as a whole will benefit. Potential new payment and service

delivery models identified include: coordinated care, disease management, Centers of Excellence, better collaboration with providers and physicians, and competitive acquisition.

Status: The report contains detailed work plans, personnel assignments and schedules, and an outline and proposed content for the interim and final reports.

02-065 Healthy Aging: Senior Risk Reduction Program

Project Officer: Pauline Lapin
Period: September 2002–November 2003
Awardee: MEDSTAT Group (DC)
Funding: $996,590

Description: The Senior Risk Reduction Program (SRRP) demonstration will test a new approach to health promotion using health risk appraisal programs. The goal is to determine if national implementation of the SRRP as a new Medicare program reduces health risks, improves self-efficacy, is cost neutral or saving, and whether participants report high levels of satisfaction with such a program.

Status: This project is in the startup phase.

01-258 Lessons Learned from State Medicaid and Pharmacy Assistance Programs

Project Officer: Cheryl Austein-Casnoff
Period: September 2001–September 2002
Awardee: American Management Systems
Funding: $463,576

Description: This project describes State innovations in addressing the cost and access to pharmaceuticals for low income individuals. It has two activities
1) assessing the impact and effectiveness of current Medicaid State program on providing affordable access to necessary prescription medications, and
2) identifying State models for low income elderly patients and describing how these programs relate to State Medicaid programs. The overall goal is to better understand how States manage their Medicaid and State-only pharmaceutical programs and to share lessons learned from their experiences.

Status: To Accounting May 16, 2002.

02-061 The Impact of Prescription Drug Coverage on Medicare Program Expenditures: A Case Study of the Evaluation of the United Mine Workers' Demonstration

Project Officer: Jennifer Shapiro
Period: September 2002–September 2003
Awardee: Abt Associates
Funding: $181,763

Description: The purpose of this project is to conduct preliminary analytic work to explore the feasibility of identifying a control group using Medicare administrative data to assess the impact of comprehensive prescription drug coverage on Medicare Part A and Part B expenditures.

01-053 Iowa Senior Discount Prescription Drug Demonstration Project

Project Officer: Ronald Deacon
Period: March 2001–September 2002
Awardee: Iowa, Department of Public Health
Funding: $1,000,000

Description: This demonstration project uses a mercantile prescription drug purchasing cooperative or non-profit "buying club" corporation to reduce the burden of prescription costs on Iowa seniors. Approximately 274,000 seniors 65 or older do not have an insured drug benefit and are not enrolled in Medicaid. The 2001 budget contains a line for an award ($1,000,000) for this project. The State plans to implement the project in late 2001. The co-op/buying club negotiates discounts or rebates with pharmaceutical companies for the cost of the drug and discounts that are passed along to the consumer. The project supports beneficiary's choosing a lower cost but therapeutically equivalent medication if recommended by a physician or pharmacist. The key elements of the demonstration include marketing, pharmacist involvement, senior pledge/commitment, pharmacy benefit manager, pharmaceutical and

therapeutics committee, physician involvement, education, and drug utilization review.

Status: The 2001 budget contains a line for an award ($1,000,000) for this project. Iowa requested and received an additional $500,000 from CMS to partially subsidize the enrollment fee, lowering it from $40 to $20. The project began enrollment in the Fall 2001 and operation in January 2002.

00-115 **Assessment of Medicare Prescription Drugs and Coverage Policies**

Project Officer: Peri Iz, Brigid Goody
Period: September 2000–July 2002
Awardee: Research Triangle Institute, (NC)
Funding: $202,527

Description: The purpose of this project is to assemble and analyze recent fee-for-service and managed care plan data on Medicare spending for prescription drugs, as well as comparable data from other public and/or private payers. Using these data, the project will estimate possible financial effects of alternative Medicare payment policies for drugs currently covered by statute. This study will estimate current expenditures and possible savings from alternative reimbursement policies based on different discount rate and price schedules used by other payers, as well as examine other purchasing polices including competitive bidding and rebate mechanisms.

Status: This project was completed in July 2002.

02-077 **Prescription Drug Coverage in Medicaid: Using Medicaid Claims Data to Develop Prescription Drug Monitoring and Analysis**

Project Officer: Rosemarie Hakim
Period: September 2002–September 2004
Awardee: Mathematica Policy Research, (DC)
Funding: $394,890

Description: The purpose of this project is to build a baseline capability to easily access information contained in Medicaid claims files for 1999. This includes creating summary tables, descriptive statistics, and graphics of utilization and expenditures of prescription drugs. Analyses involve drug utilization and expenditures in the context of State policies regarding use of generics, formularies, and restrictions on numbers of prescriptions.

Status: This activity is expected to result in a peer-reviewed paper.

99-035 **Analysis of Medicare Beneficiary Baseline Knowledge Data Using MCBS**

Project Officer: Sherry Terrell
Period: June 1999–June 2002
Awardee: University of Wisconsin - Madison
Funding: $229,123

Description: The purpose of this project was to analyze Medicare beneficiary baseline program knowledge data collected through the Medicare Current Beneficiary Survey (MCBS) in CY 1995-1997 and CY 1998 to determine data usefulness for program evaluation. The program objective was to evaluate National Medicare Education Program (NMEP) print material (Handbook: 1999 and Bulletin) and selected information distribution channels (print, Internet, 1-800-MEDICARE). The policy objective was to support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and continuous quality improvement of NMEP informational materials directed to the Medicare population over time.

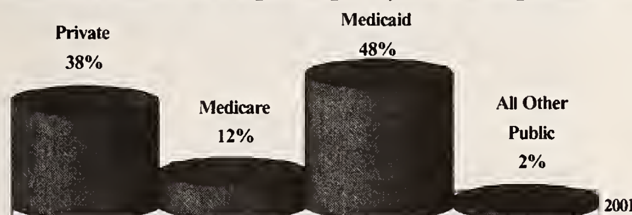
Status: This project has been completed. In Phase I data analyses, several working measures of beneficiary Medicare program knowledge were constructed, validated and used to develop MCBS supplemental knowledge questions. In the Phase II analyses of CY 1998 data, these knowledge indexes were used to compare beneficiaries' program knowledge across program and policy variables of interest. Although only 24 percent of respondents reported reading all or some of the Medicare&You 1999 Handbook or Bulletin,

these beneficiaries had significantly higher program knowledge scores, approximately 5 to 7 percentage points, than did those who did not read the handbook (bulletin). For each of the NMEP goals examined--access, awareness, understanding, and use--reading the 1999 handbook made a difference. Paper copy and microfiche copies of the final reports may be ordered from the National Technical Information Service by referencing the following NTIS accession numbers:- Analysis of Medicare Beneficiary Baseline Knowledge Data from the Medicare Current Beneficiary Survey: Knowledge Index Technical Note" (May 2000) PB2001-102026.- Analysis of Baseline Measures in the Medicare Current Beneficiary Survey for Use in Monitoring the National Medicare Education Program: Final Phase One Report (November 2000) PB2001-104030.- Analysis of the 1998 Medicare Current Beneficiary Survey for Use in Monitoring the National Medicare Education Program: Phase Two Final Report (December 2000) PB2001-102747. Electronic copies of the above reports are also accessible from the CMS web page at http://www.cms.hhs.gov/researchers/projects/.

Theme 5: Strengthening Medicaid, State Children's Health Insurance Program (SCHIP), and State Programs

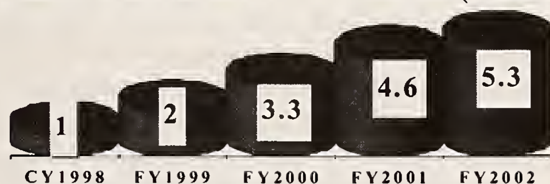
This effort includes research on ways to improve access to and delivery of health care to the persons served by the Medicaid and State Children's Health Insurance Programs and to the uninsured. Our research and demonstrations regarding disabled populations include the Demonstration to Maintain Independence and Employment, mandated by the Ticket to Work and Work Incentives Improvement Act of 1999, and the Nursing Home Transition Grant program. Research and demonstration projects for children include the Medicaid Oral Health Demonstration, the Children's Hospice Care Demonstration, research to identify model approaches, studies of the effects of the Medicaid coverage expansions for children, outcome and expenditure effects of preventive services for children, analysis of early intervention for Medicaid children with asthma, and the evaluation of Medicaid managed care delivery systems. Our research and demonstrations regarding Health Insurance Portability and Accountability Act insurance reform provisions include high-risk pool analyses, studies of how associations are treated by State insurance reform laws, and evaluation of State laws governing associations.

Medicaid Remains the Largest Single Payer of Nursing Home Care



Note: Hospital-based Skilled Nursing Facilities are excluded.
Source: *CMS, Office of the Actuary, National Health Statistics Group.*

The Number of Kids Enrolled in SCHIP 1998-2002 (in millions)



Source: *CMS, FY2002 SCHIP Annual Enrollment Report.*

95-049 **Montana Welfare Reform: Families Achieving Independence in Montana (FAIM)**

Project Officer:	Joan Peterson
Period:	February 1996–January 2004
Awardee:	Montana, Department of Public Health and Human Services
Funding:	$0

Description: The Montana demonstration established statewide: 1) a Job Supplement Program consisting of a set of Aid to Families with Dependent Children (AFDC)-related benefits to assist individuals at risk of becoming dependent upon welfare; 2) AFDC Pathways Program, in which all applicants had to enter into a family investment agreement requiring parents to secure child support, obtain early, periodic screening, diagnosis and treatment services and immunizations for their children, and participate in the State's Jobs Opportunity and Basic Skills program, and limiting adults' benefits to a maximum of 24 months for single parents and 18 months for two-parent families; and 3) a community services program requiring 20 hours per week for individuals who reach the AFDC time limit but have not achieved self-sufficiency. Montana expanded AFDC-Unemployed Parent eligibility and increased the resource and automobile equity limits for AFDC and Food Stamp recipients. The State also increased the dependent care disregard, as well as disregards of energy assistance payments, earned income of dependent children in school, gifts of money for special occasions, and child support payments made to non-household members for AFDC and Food Stamp purposes. Under its demonstration, enrollment of adult participants in a health maintenance organization (HMO) is mandated where geographically available. In areas where an HMO is not available, Montana offers basic Medicaid coverage through "Passport to Health," Montana's primary-care case-management program.

Status: Montana elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstration.

96-043 Tennessee "Families First" Demonstration

Project Officer: Alisa Adamo
Period: September 1996–September 2006
Awardee: Tennessee, Department of Human Services
Funding: $0

Description: "Families First" is a welfare demonstration. CMS approved waivers of the specific Medicaid regulations to provide 18 months of transitional Medicaid to people regardless of the reason for Aid to Families and Dependent Children (AFDC) case closure and/or whether the person was on AFDC for 3 out of the preceding 6 months.

Status: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) permitted States to continue many of the policies that had previously required waivers of pre-welfare reform by submitting a Temporary Assistance for Needy Families (TANF) plan to the Administration for Children and Families (ACF). Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstrations.

95-068 A Better Chance Welfare Reform Project

Project Officer: Alisa Adamo
Period: October 1995–December 2003
Awardee: Delaware, Health and Social Services, (New Castle)
Funding: $0

Description: The Better Chance Welfare Reform Demonstration was designed to test a set of provisions that linked opportunity and responsibility, supports the formation and maintenance of two-parent families, provided positive incentives for private sector employment, and reduced teenage pregnancy. To reinforce these work and education requirements, the State is providing some additional benefits, such as an additional year of transitional Medicaid and transitional child care. Medicaid waivers were required to provide demonstration recipients 12 additional months of transitional Medicaid if their income is under 100 percent of the Federal poverty level.

Status: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) allows States to continue many of the policies that had previously required waivers of pre-welfare reform title IV-A by submitting a Temporary Assistance for Needy Families (TANF) plan to the Administration for Children and Families (ACF). In some instances, States elected to retain waivers of pre-welfare reform title IV-A through the end of the demonstration period. Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstrations.

96-044 Achieving Change For Texans

Project Officer: Alisa Adamo
Period: April 1996–April 2002
Awardee: Texas, Department of Human Services
Funding: $0

Description: "Achieving Change For Texans" is a welfare demonstration and contains a wide range of innovative welfare reform initiatives. Under the demonstration, Aid to Families with Dependent Children (AFDC) recipients must attend school if they are under 19 years of age, cooperate with support collection and paternity establishment efforts, abstain from using drugs and abusing alcohol, provide health checkups and immunizations for their children, and ensure that their children attend school. The demonstration sets variable time limits for adult recipients' AFDC benefits, based on the education level and work experience of the adult recipients. The demonstration includes exemptions for those who cannot work and extensions for severe personal hardship for those who live in economically distressed

areas. Families will retain Medicaid benefits if AFDC is terminated upon reaching the time limit. An additional 6 months of transitional Medicaid is meant to be an incentive for exempt cases to voluntarily participate in the Jobs Opportunity and Basic Skills program. The CMS waiver was needed in order to implement this component of the demonstration.

Status: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) permitted States to continue many of the policies that had previously required waivers of pre-welfare reform by submitting a Temporary Assistance for Needy Families (TANF) plan to the Administration for Children and Families (ACF). Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstrations.

96-047 **New Hampshire Employment Program and Family Assistance Program**

Project Officer: Maria Boulmetis
Period: July 1996–March 2002
Awardee: New Hampshire, Department of Health and Human Services, (Hazen Dr)
Funding: $0

Description: This statewide demonstration increases the requirements on recipients to seek and to obtain work, allows the recipients to keep more of their earnings and have more exempt resources, and streamlines eligibility for both Aid to Families with Dependent Children (AFDC) and AFDC-related Medicaid individuals to reflect demonstration provisions. Individuals are also allowed to receive transitional Medicaid benefits even though they did not receive AFDC in 3 out of the previous 6 months.

Status: The State continues to implement the demonstration.

98-235 **Impact of Welfare Reform on Medicaid Populations**

Project Officer: Penelope Pine
Period: September 1998–February 2002
Awardee: Mathematica Policy Research, (DC)
Funding: $685,790

Description: This project develops data and examines the impact of welfare reform on Medicaid eligibility, utilization, and payments for various populations. It will study the effect of: 1) delinking Aid to Families with Dependent Children and Medicaid eligibility; 2) terminating access to Medicaid for some legal immigrants because they lost eligibility for Supplemental Security Income; 3) barring most future legal immigrants from Medicaid; and 4) narrowing Medicaid eligibility for selected disabled children and disabled alcohol and substance abuse populations.

Status: Trend analysis of Medicaid eligibility 1993-1997 is in progress. The first paper from this project, entitled "Medicaid Eligibility, Takeup, Insurance Coverage and Health Access and Use Before and After Welfare Reform: National Changes from 1994-1997 Using National Health Interview Survey" is available.

95-047 **Arizona Welfare Reform: Employing and Moving People Off Welfare and Encouraging Responsibility Program**

Project Officer: Joan Peterson
Period: May 1995–October 2002
Awardee: Arizona, Department of Economic Security
Funding: $0

Description: The Arizona statewide demonstration did not increase benefits for additional children conceived while the mother was receiving Aid to Families with Dependent Children (AFDC), but limited benefits to adults to 24 months in any 60-month period and allowed recipients to deposit up to $200 per month

(with 50 percent disregarded) in Individual Development Accounts. It requires mothers who are minors to live with parents, extends transitional child care and Medicaid to 24 months, and it eliminates the 100-hour rule for AFDC-Unemployed Parent cases.

Status: Arizona elected to retain the waivers and expenditure authorities granted by CMS as part of the welfare reform demonstration.

95-069 Massachusetts Welfare Reform, 1995

Project Officer: Alisa Adamo
Period: November 1995–November 2005
Awardee: Executive Office of Health and Social Services
Funding: $0

Description: The major components of this demonstration were a 2-year time limit on Aid to Families with Dependent Children (AFDC) within every 60 months, with extensions in certain cases, and a work requirement for those on AFDC for more than 60 days. Certain recipients were exempt from the time limit and the work requirement (e.g., the disabled, pregnant women). Recipients who were not exempt were asked to sign an Employment Development Plan. The plan addressed such requirements as school attendance for children and minor parents, immunizations for children, and employment-related requirements for adults. Additional incentives are being provided to encourage people to work. These include income disregards and transitional Medicaid. Medicaid waivers were required in order to provide 12 months transitional Medicaid to families without regard to income.

Status: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) on August 22, 1996, permits States to continue many of the policies that had previously required waivers of pre-welfare reform title IV-A by submitting a Temporary Assistance for Needy Families (TANF) plan to the Administration for Children and Families (ACF). Unless otherwise indicated, States have elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstrations.

95-063 Virginia Independence Program

Project Officer: Maria Boulmetis
Period: July 1995–June 2003
Awardee: Virginia, Department of Health and Human Services
Funding: $0

Description: This statewide program provides a one-time diversion payment to applicants instead of Aid to Families with Dependent Children (AFDC), tightens sanctions for jobs opportunity and basic skills training programs, requires paternity establishment within 6 months, requires minor parents to live with adult guardians, eliminates a benefit increase for a baby born to a mother on welfare, requires AFDC caretakers without a high school diploma to attend school, requires child immunizations, increases resource limits, and gives transitional child care and Medicaid benefits to cases losing AFDC eligibility for any reason and if they have no coverage through an employer group health plan and have incomes below 185 percent of Federal poverty guidelines. The Virginia Initiatives for Employment not Welfare (VIEW) would phase in a statewide program over 4 years. VIEW will assign participants to a work activity within 90 days of a benefit receipt, provide employer subsidies from AFDC plus the value of Food Stamps, time-limit AFDC benefits to 24 consecutive months, apply full-family AFDC cash sanctions for refusal to cooperate with work programs, increase earned-income disregards up to Federal poverty guidelines, and provide 12 months of transitional transportation assistance.

Status: The State continues to implement the demonstration.

95-062 Nebraska Welfare Reform Demonstration Project

Project Officer: Maria Boulmetis
Period: July 1995–July 2002
Awardee: Nebraska, Department of Social Services
Funding: $0

Description: Statewide waivers permit Nebraska to limit employable adults to a maximum of 24 months of Medicaid in any 48-month period and require employable adults to participate in employment-related activities with more stringent sanctions for non-cooperation. Cases that lose Aid to Families with Dependent Children eligibility due to earnings will receive a 24-month Medicaid transition benefit. The Medicaid transition benefit will involve quarterly income reporting, with the case losing eligibility when income exceeds 185 percent of the Federal poverty guideline, and the State may also impose cost sharing in months 7-24 of the transition benefit.

Status: The State continues to implement the Medicaid waivers for the small group of clients who remain eligible.

96-063 South Carolina Welfare Reform: Family Independence Act

Project Officer: Joan Peterson
Period: June 1996–May 2003
Awardee: South Carolina, Department of Health and Human Services
Funding: $0

Description: This project limited Aid to Families with Dependent Children (AFDC) cash benefits to families with able-bodied adults to 24 months; allowed relocation, under certain criteria, for a family to receive a good-cause extension of AFDC cash benefits; required applicants and recipients to sign Individual Self-Sufficiency Plans (ISSPs) outlining employment and training requirements and family skills training; allowed random testing in conjunction with substance abuse treatment; imposes progressive fiscal sanctions which may result in a full-family sanction for failure to comply with the ISSP; required up-front job search as a condition of eligibility and required job-ready individuals to participate in alternate work experience; imposes a family cap, but provided benefits to affected children in the form of vouchers/commodities; eliminated principal earner provisions, work history requirements, and the 100-hour rule for AFDC-Unemployed Parent cases. The Family Independence Act also provided transitional child care and transitional Medicaid for up to 24 months and without regard to prior AFDC receipt. Medicaid eligibility is continued for individuals for up to 90 days after termination of AFDC benefits due to the removal of dependent child(ren) from the home because of abuse or neglect if the individual is participating in substance abuse treatment.

Status: South Carolina elected to retain the waivers and expenditures authorities granted by CMS as part of the welfare reform demonstration.

02-031 Development and Evaluation of Medical Intervention for Early Childhood Caries

Project Officer: Teresa Brocato
Period: September 2000–September 2003
Awardee: North Carolina, Department of Health and Human Services
Funding: $440,000

Description: This project is aimed at training physicians and physician extenders (i.e., physician assistants, nurse practitioners) in furnishing a package of preventive dental services to both children and their caregivers in order to reduce the incidence and transmission of dental decay in children. This innovative project effectively will expand two original, small demonstrations to the rest of the State. Three methods of training primary care providers will be tested, using a prospective, randomized study design, on the 84 largest-volume medical practices in North Carolina. These practices provide services to over 100,000 young children enrolled in Medicaid. This project will develop educational materials and track the short- and long-term effects of the education on physician knowledge and resulting dental services.

Medical claims will be analyzed to compute the rates and intensity of services provided. By documenting the outcomes of these training methods in terms of their ability to deliver low cost preventive dental services for children in the primary care setting, this project has potential to accelerate the rate of adoption, and set new standards for delivery.

Status: In addition to completing initial organizational activities, the project has provided training to more than 117 medical practices and 64 local health departments, and 3,326 children have received at least the initial preventive oral health service. As of December 2001 the project was moving smoothly into its second operational year. They are meeting their expected enrollment/participation levels.

02-032 Innovative Management of Dental Decay for Young Children Enrolled in Medicaid and/or the State Children's Health Insurance Program (SCHIP)

Project Officer: Teresa Brocato
Period: September 2001–September 2003
Awardee: California, Department of Health Services
Funding: $420,000

Description: This demonstration is a joint project of the California Medicaid program (MediCal) and the University of California San Francisco (UCSF) School of Dentistry designed to improve dental access for young children, and reduce caries rates and the high costs of dental care. In the target population of Alameda County, the State will conduct an outreach enrollment campaign; orient families to expectations and responsibilities; recruit, train, and certify medical and dental providers in innovative preventive and therapeutic services; and enhance Medicaid reimbursement to certified providers. Comparisons of utilization rates and expenditures will be made between the intervention population and a control group of children who are eligible for, but not enrolled in, the program.

Status: The California project was delayed; however, the operational phase began April 2002.

Program of All-Inclusive Care for Children

This project is part of a CMS grant to the State for research and evaluation activities culminating in the development of a demonstration program specifically designed for improving the services available to children with life-threatening conditions and their families. The Program of All-Inclusive Care for Children (PACC) is a model of care that will be established in the State through that demonstration. PACC integrates all health care, social services, and support services needed by families to care for children diagnosed with life-threatening and potentially life-limiting conditions. PACC provides these services at the point of diagnosis of a terminal illness and continues through the provision of bereavement counseling after the end of life.

00-098 Program of All-Inclusive Care for Children–Florida

Project Officer: Melissa Harris
Period: September 2000–September 2002
Awardee: Florida, Agency for Health Care Administration, (Ft Knox Blvd)
Funding: $198,330

Description: The primary goal of the Florida program is to maintain these children in their home, which would be less costly and more likely to achieve patient and family/caregiver satisfaction. Initially, the State will pilot this project in limited geographic areas, and may limit participation in the project to children with specific life-threatening diagnoses until Florida is able to expand the program to include all diagnoses.

Status: The State of Florida, Agency for Health Care Administration, was awarded grant funding for a 1-year period of September 2000 through September 2001.

Maintain Independence and Employment Program–Infrastructure Grant

The Medicaid Infrastructure Grants program enables States to build needed systems to help people with disabilities purchase health coverage through Medicaid. Grant funds assist employers' access to this underused pool of workers, conduct outreach to people with disabilities, train staff in new employment possibilities, and improve transportation and other supports for people with disabilities. The goal of this grant is to support people with disabilities in securing and sustaining competitive employment in an integrated setting. The Infrastructure Grants program provides financial assistance to States through a Medicaid buy-in mechanism under the State Medicaid Plan; the ability to purchase Medicaid coverage for people with a severe impairment who do not yet meet the Social Security Insurance (SSI) disability test; significant improvements to Medicaid services that support people with disabilities in their competitive employment efforts; and/or serve as a regional State-to-State Medicaid Infrastructure Center.

01-011 Maintain Independence and Employment Program–Infrastructure Grant–Alabama

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Alabama, Medicaid Agency, Long Term Care Division
Funding: $625,000

Status: The Alabama program involves Medicaid buy-in activities, such as exercising the BBA Medicaid Coverage Option for income above 250 percent FPL, including those who do not meet SSI disability test but have a potentially severe physical impairment. Medicaid services improvements involve a workgroup of individuals with disabilities, consumer and advocacy groups, potential employers, and other stakeholder representatives who will identify and develop a comprehensive list of issues and concerns of employed people with disabilities and through the Homeward Bound Waiver Services, provide personal assistance service benefits for daily living on and off the job, and an education program for disabled individuals on, specifically, the TWWIIA provisions.

01-017 Maintain Independence and Employment Program–Infrastructure Grant–Alaska

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Alaska, Governor's Council on Disabilities and Special Education
Funding: $625,000

Status: The Alaska project involves Medicaid buy-In activities such as assessing why people do not join the Medicaid buy-in; what measures can be taken to increase participation; assessing the impact and cost-effectiveness of a buy-in program; and outreach to people with disabilities, service providers, employers, and State and Federal agencies. Improving Medicaid services involves training and technical assistance regarding Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) provisions, changes to Medicare, and changes in independent personal assistance services programs.

02-019 Maintain Independence and Employment Program–Infrastructure Grant–California

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: California, Department of Health Services
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

02-007 Maintain Independence and Employment Program–Infrastructure Grant–Colorado

Project Officer: Kay Lewandowski
Period: January 2002–December 2004
Awardee: Colorado, Department of Health Care Policy and Financing
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-018 Maintain Independence and Employment Program–Infrastructure Grant–Connecticut

Project Officer: Jeremy Silanskis
Period: October 2000–December 2004
Awardee: Connecticut, Department of Social Services
Funding: $625,000

Status: The Connecticut program involves Medicaid buy-in activities, such as conducting outreach targeted at individuals who may be eligible for the State's program, exploring the programmatic and fiscal impact of expanding personal assistance services beyond the current populations and scope of services, and developing a competent, flexible, culturally sensitive, adequately compensated workforce for providing necessary supports and services to individuals with disabilities in competitive employment.

02-008 Maintain Independence and Employment Program–Infrastructure Grant–Delaware

Project Officer: Jeremy Silanskis
Period: January 2002–December 2004
Awardee: Delaware, Health Care Commission
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-027 Maintain Independence and Employment Program–Infrastructure Grant–District of Columbia

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: District of Columbia, Department of Health, Medical Assistance Administration
Funding: $500,000

Status: The District of Columbia program involves Medicaid buy-in activities, including attendant services, rehabilitation services, home and community based personal assistance services, services outside the home, non-emergency services, transportation services, technologies, and environmental adaptations. Activities also include benefit design, cost modeling, staffing and information systems requirements, eligibility requirements, premium collection, tax options for employers, independent savings accounts, training options, outreach, educational materials and development, and initial administrative implementation. Improvement to Medicaid services involve a leadership council, an integrated system for disabled District residents to access care and services, informational materials on services and supports, eligibility requirements, enrollment processes, and health benefit options, and personal assistance services. Other improvements include amending the Elderly Waiver to include the under 65 years of age population, monitoring the number of disabled residents willing and able to work, assessing their skills, identifying training, services and support needs and employment opportunities.

01-026 Maintain Independence and Employment Program–Infrastructure Grant–Georgia

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Georgia, Department of Community Health
Funding: $625,000

Status: The Georgia program involves Medicaid buy-in activities, and improved Medicaid services. Activities include outreach and training programs targeted at consumers using a peer support model; offer providers greater incentives for employment outcomes; waiver-funded personal support services for employment, a jobs hot line, peer support networks, and marketing material from several media to assist in employment; and a data base to track outcomes for workers.

01-022 Maintain Independence and Employment Program–Infrastructure Grant–Idaho

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Idaho, Department of Health and Welfare, (Amer. Terr)
Funding: $625,000

Status: The Idaho program involves Medicaid buy-in activities such as benefit representatives, steering committees, public input forums, educational materials, and enhanced Medicaid data systems. Improved Medicaid services include increased availability of personal assistance services, recommendations on transportation, and improved employment opportunities for individuals with disabilities.

01-025 Maintain Independence and Employment Program–Infrastructure Grant–Illinois

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Illinois, Department of Public Aid, (South Grand Ave)
Funding: $625,000

Status: The Illinois program involves Medicaid buy-in activities, such as improving the administration process, tracking premium payments, and billing procedures; ensuring individuals eligible for the Medicaid buy-in are made aware of existing Medicaid options; an Advisory Council, information systems; and education to advocacy organizations, service providers, personnel of other State agencies, interested labor organizations, employers, and interested service and community organizations.

02-010 Maintain Independence and Employment Program–Infrastructure Grant–Illinois

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: Illinois, Department of Public Aid, (South Grand Ave)
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-023 Maintain Independence and Employment Program–Infrastructure Grant–Iowa

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: Iowa, Department of Human Services
Funding: $1,296,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-013 Maintain Independence and Employment Program–Infrastructure Grant–Kansas

Project Officer: Karen Tritz
Period: October 2000–December 2004
Awardee: Kansas, Department of Social and Rehabilitation Services
Funding: $529,117

Status: The Kansas program involves Medicaid buy-in activities, such as incorporating the two new eligibility groups offered under Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) legislation, and provides personal assistance services within the State plan to support employment opportunities for those individuals eligible for the new program. Improvements to Medicaid services include more choices in purchasing services, an advisory group and an inter-agency group to help aid in policy development for Medicaid infrastructure change, and managing premium collection and necessary changes in the State's information systems.

02-012 Maintain Independence and Employment Program–Infrastructure Grant–Louisiana

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: Louisiana, Department of Health and Hospitals
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-010 Maintain Independence and Employment Program–Infrastructure Grant–Maine

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Maine, Department of Human Services
Funding: $1,082,963

Status: In Maine the program involves Medicaid buy-in activities and improving existing Medicaid buy-in program.

01-021 Maintain Independence and Employment Program–Infrastructure Grant–Massachusetts

Project Officer: Karen Tritz
Period: October 2000–December 2004
Awardee: University of Massachusetts Medical School, Office of the Chancellor
Funding: $625,000

Status: The Massachusetts program involves Medicaid buy-in activities, such as evaluation and research projects, a monitoring plan, and assessment of program changes. Improving Medicaid services involves coordination of activities of various State agencies and private organizations dealing with improving the employability of Medicaid eligible individuals with disabilities, communication plans for disability and employer communities, and assessment of consumers encounter access during major transitions.

01-015 Maintain Independence and Employment Program–Infrastructure Grant–Minnesota

Project Officer: Jeremy Silanskis
Period: October 2000–December 2004
Awardee: Minnesota, Department of Human Services
Funding: $625,000

Status: The Minnesota program involves Medicaid buy-in activities such as creating a web-based tool kit for potential users and buy-in recipients. Medicaid services improvements include revamping the State Medicaid web-site, establishing a disability phone link to enhance employment-related information resources, issuing mini-grants to local consumer assistance and advocacy organizations, developing training materials, and offering training and other educational opportunities on, for example, Social Security Insurance (SSI) and Social Security Disability Insurance (SSDI) work incentives, and changes to Medicare.

01-012 Maintain Independence and Employment Program–Infrastructure Grant–Missouri

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: Missouri, Department of Social Services
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-008 Maintain Independence and Employment Program–Infrastructure Grant–Nebraska

Project Officer: Aaron Blight
Period: October 2000–December 2004
Awardee: Nebraska, Department of Health and Human Services
Funding: $625,000

Status: The Nebraska program involves Medicaid buy-in activities, such as a study of the fiscal impact and cost benefit analysis of Medicaid buy-in programs in other States. Medicaid services improvements include one or more pilot projects on personal assistance services, and the elimination of other barriers to employment:

- A work incentives project advisory committee of employers to address commonly held concerns over the employment of disabled individuals
- A marketing/communication plan for consumers to include a TWWIIA website, which will offer information, dialogue, education, and support to Nebraskans with special needs and their families.

02-006 Maintain Independence and Employment Program–Infrastructure Grant–Nebraska

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: Nebraska, Department of Health and Human Services
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-020 Maintain Independence and Employment Program–Infrastructure Grant–Nevada

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Nevada, Department of Human Resources
Funding: $625,000

Status: The Nevada program involves Medicaid buy-in activities such as, analyzing the cost effectiveness of a Medicaid buy-in program; forming an advisory board; implementing outreach; referral/information; service delivery; case management; early intervention to support the Medicaid buy-in; improving Medicaid services including providing Personal Assistance Services, provider education, workplace assistance training, and informational materials on available Medicaid programs.

01-004 Maintain Independence and Employment Program–Infrastructure Grant–New Hampshire

Project Officer: Jeremy Silanskis
Period: October 2000–December 2004
Awardee: New Hampshire, Department of Health and Human Services, (Pleasant St.)
Funding: $500,000

Status: The New Hampshire program involves Medicaid buy-in activities, supports One-Stop Centers that offer competent healthcare counseling so persons with disabilities may access the buy-in program, provides a health insurance expert at each One-Stop location, and purchases and installs needed software. Improved Medicaid services include consumer guidance; provide seed money to local communities to create the infrastructure, outreach strategies to train and educate the public, persons with disabilities, their families, businesses, providers, and State staff on buy-in and TWWIIA programs; and expand the delivery of services that makes access to health insurance for persons with disabilities a more integrated process and improves the availability of appropriate community-responsive services.

01-006 Maintain Independence and Employment Program–Infrastructure Grant–New Jersey

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: New Jersey, Department of Human Services
Funding: $625,000

Status: The New Jersey program involves Medicaid buy-in activities, such as coverage to working individuals with disabilities whose family income does not exceed 250 percent of the Federal poverty level (FPL). Improved Medicaid services include, for case management, more effective public transportation services, expansion of existing personal assistance services, and assistance to individuals with disabilities in understanding the existing and new work incentives programs. Personal care services are provided through

a marketing campaign, extensive outreach to consumers with disabilities, and a management information system to monitor evolving Medicaid infrastructure.

01-009 Maintain Independence and Employment Program–Infrastructure Grant–New Mexico

Project Officer: Jeremy Silanskis
Period: October 2000–December 2004
Awardee: New Mexico, Department of Human Services, Medical Assistance Division
Funding: $499,575

Status: The New Mexico program involves Medicaid buy-in activities, such as outreach and educational efforts utilizing peer presenters with disabilities. Statewide Medicaid services improvements include consumer groups to assist in the development, delivery and fine-tuning of work incentives activities; advisory groups comprised of consumers, service providers, parents, advocates, and State agency personnel to oversee the project; and training and technical assistance. There is also an expansion of existing linkages between the Medical Assistance Division of the Human Services Department and the Comprehensive Health Insurance Pool (CHIP), a private health insurance plan for individuals with pre-existing disabling conditions.

02-015 Maintain Independence and Employment Program–Infrastructure Grant–New York

Project Officer: Kay Lewandowski
Period: January 2002–December 2004
Awardee: New York, Department of Health, (Albany)
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

02-018 Maintain Independence and Employment Program–Infrastructure Grant–North Dakota

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: Minot State University
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

02-003 Maintain Independence and Employment Program–Infrastructure Grant–Ohio

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: Ohio, Department of Job and Family Services
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

02-004 Maintain Independence and Employment Program–Infrastructure Grant–Oklahoma

Project Officer: Jeremy Silanskis
Period: January 2002–December 2004
Awardee: Oklahoma, Health Care Authority
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-007 Maintain Independence and Employment Program–Infrastructure Grant–Oregon

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Oregon, Department of Human Services
Funding: $625,000

Status: The Oregon program involves Medicaid buy-in activities, and Medicaid services improvements. The program allows for opportunities to enhance associated social support services, and information dissemination through website links, and a clearinghouse. It increases consumer participation, develops training activities, expands involvement of advocacy groups, improves consumer choices and benefits counseling networks, develops outreach programs and strengthen links to employers.

02-009 Maintain Independence and Employment Program–Infrastructure Grant–Pennsylvania

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: Pennsylvania, Department of Public Welfare
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-016 Maintain Independence and Employment Program–Infrastructure Grant–Rhode Island

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Rhode Island, Department of Human Services
Funding: $625,000

Status: The Rhode Island program involves Medicaid buy-in activities, such as convening workgroups to develop action plans for the passage of legislation to increase eligibility in accordance with the new Medicaid buy-in eligibility groups under Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). Improved Medicaid services include communication strategies, benefit counselors, a new premium subsidy program, a system that ensures the State has access to timely and accurate data about employer-based health insurance, and early intervention strategies to get and keep people employed.

02-011 Maintain Independence and Employment Program–Infrastructure Grant–South Dakota

Project Officer: Joe Razes
Period: January 2002–December 2004
Awardee: South Dakota, Department of Human Services
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

02-013 Maintain Independence and Employment Program–Infrastructure Grant–Texas

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: Texas, Health and Human Services Commission
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-005 Maintain Independence and Employment Program–Infrastructure Grant–Utah

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Utah, Department of Health
Funding: $625,000

Status: The Utah program involves Medicaid buy-in activities, such as coverage to working individuals with disabilities whose family income does not exceed 250 percent of the Federal poverty level (FPL). Improved Medicaid services include, for case management, more effective public transportation services, expansion of existing personal assistance services, and assistance to individuals with disabilities in understanding the existing and new work incentives programs. Personal care services are provided through a marketing campaign, extensive outreach to

consumers with disabilities, and a management information system to monitor evolving Medicaid infrastructure.

02-005 Maintain Independence and Employment Program–Infrastructure Grant–Virginia

Project Officer: Karen Tritz
Period: January 2002–December 2004
Awardee: Virginia, Department of Medical Assistance Ser5vices
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

01-019 Maintain Independence and Employment Program–Infrastructure Grant–Washington

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: Washington, Department of Social and Health Services
Funding: $625,000

Status: The Washington program involves Medicaid buy-in activities such as a modified premium billing and collection system, client education, data reporting, and referral to appropriate services to help individuals with disabilities become competitively employed. Activities also include changing information systems to allow for effective tracking in the State's new buy-in program; access employment security wage information for buy-in program participants to monitor employment, wages, and job announcement/wage programs; and identify the types of agency services received by buy-in participants over time. Improved Medicaid services include a State Personal Assistance Recruitment and Retention program, training on new programs dealing with Social Security Insurance/Social Security Disability Insurance recipients, and work incentives programs.

01-003 Maintain Independence and Employment Program–Infrastructure Grant–West Virginia

Project Officer: Kay Lewandowski
Period: October 2000–December 2004
Awardee: West Virginia, Division of Rehabilitation Services
Funding: $624,994

Status: The West Virginia program involves Medicaid buy-in activities, Medicaid services improvements, and a plan to amend Medicaid State plan to provide personal assistance services outside of the home. The grant also funds community outreach and education to persons with disabilities, their families and agencies that work with them.

02-017 Maintain Independence and Employment Program–Infrastructure Grant–Wyoming

Project Officer: Kay Lewandowski
Period: January 2002–December 2004
Awardee: Wyoming Institute for Disabilities, University of Wyoming
Funding: $500,000

Status: This award is made to allow the State to develop the infrastructure that will support the development of demonstration[s].

Maintain Independence and Employment Demonstration

This project allows States to assist working individuals by providing necessary benefits and services required for people to manage the progression of their conditions and remain employed. It is a grant program established by the Ticket to Work and Work Incentives Improvement Act of 1999. The goal is to explore if providing health care to people earlier than traditional Medicaid rules allow will lengthen the person's work life and improve their quality of life. Outcomes to be measured include reliance on cash benefits, employment status, changes in health status, and quality of life.

02-002 Maintain Independence and Employment Demonstration–District of Columbia

Project Officer: Joe Razes
Period: January 2002–January 2007
Awardee: District of Columbia, Department of Health, Medical Assistance Administration
Funding: $3,980,308

Status: In progress.

01-002 Maintain Independence and Employment Demonstration–Mississippi

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Mississippi, Office of Governor, Division of Medicaid
Funding: $4,754,750

Description: 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.

Status: State staff have been working closely with CMS, and the evaluation contractor, during the last several months. The evaluation phase of the project is nearly finished. The State expects to begin enrolling individuals in the project as early as June 2002.

01-001 Maintain Independence and Employment Demonstration–Rhode Island

Project Officer: Joe Razes
Period: October 2000–December 2004
Awardee: Rhode Island, Department of Human Services
Funding: $54,100

Description: The Rhode Island project uses grant funding, in conjunction with State funds, to provide the full Medicaid benefit package, plus extra services such as targeted case management, personal assistance services, pharmaceutical co-payments and other employment supports to individuals.

Status: The Rhode Island legislature failed to provide funding for this project last year. The Rhode Island legislature will meet this spring (2002) to vote on appropriating the State match for the project. The earliest the project can begin is fall 2002, assuming that funds are obligated for the project.

02-001 Maintain Independence and Employment Demonstration–Texas

Project Officer: Joe Razes
Period: January 2002–January 2007
Awardee: Texas, Health and Human Services Commission
Funding: $284,253

Status: In progress.

01-113 Evaluation of the Demonstration to Maintain Independence and Employment (DMIE) and Other Related Disease-Specific 1115 Waiver Programs

Project Officer: Arthur Meltzer
Period: September 2001–September 2006
Awardee: Health Economics Research
Funding: $2,211,678

Description: This project evaluates several demonstrations providing supplemental Medicaid benefits to persons with certain physical or mental conditions that, in the absence of such benefits, may result in decreased functional status or inability to gain employment or remain employed. The evaluations assess the association between enhanced Medicaid eligibility and healthcare costs; changes in employment status, health status and quality-of-life; and other factors among demonstration participants relative to non-participants. The demonstrations allow States to assist working individuals by providing the necessary benefits and services required for people to manage the progression of their conditions and remain employed, and allow CMS to assess the impact of the provision of Medicaid benefits on extended productivity and increased quality of life. The demonstration provides States the opportunity to evaluate whether providing such workers with early access to Medicaid services delays the progression to actual disability.

Status: This project is in the startup phase.

02-069 Medicaid Buy-In Outcomes Work Incentives Systems–Ticket to Work and Work Incentives Improvement Act

Project Officer: Joseph Razes
Period: September 2002–September 2003
Awardee: Mathematica Policy Research, (DC)
Funding: $180,736

Description: This task order is to conduct an analysis of State outcomes where working individuals with disabling conditions have enrolled in a Medicaid buy-in under the Balanced Budget Act or Ticket to Work and Work Incentives Improvement Act. Information to be analyzed includes core data elements using administrative and population-based data sets. Specific study questions addressed are: 1) what are the outcomes for workers with disabling conditions in States that offer Medicaid coverage via a Medicaid buy-in; 2) what general observations from the data can be drawn, and what lessons have we learned from States offering Medicaid buy-ins; and 3) what additional information is needed to better assess the effectiveness of Medicaid buy-ins, and what are some of the policy implications that need further study.

Status: In progress.

Medicaid Payment Accuracy Measurement Project

The Medicaid Payment Accuracy Measurement (PAM) Project will develop and pilot test several methodologies that CMS will use to 1) identify State-specific payment accuracy rates, 2) compare payment accuracy between States, 3) estimate payment accuracy nationally, and 4) assist with the creation of statistical sampling designs that produce statistically valid results on both macro and micro problem identification. The Payment Accuracy Rate is essential for accurately determining the extent of improper payment and in helping to determine where to invest resources to improve the payment system. This project identifies methodologies that are effective for States and are valid for State-to-State comparisons and determines the feasibility of a national estimate. It begins with a pilot test with nine States and is expected to expand to fifteen States. The Medicaid PAM Project is being supported by Health Care Fraud and Abuse Control (HCFAC) funds.

01-143 Medicaid Payment Accuracy Measurement Project

Project Officer: Wayne Slaughter
Period: September 2001–September 2003
Awardee: Lewin Group
Funding: $856,645

01-224 Medicaid Payment Accuracy Review Project - Louisiana

Project Officer: David McNally
Period: September 2001–September 2003
Awardee: Louisiana, Department of Health and Hospitals
Funding: $1,905,400

01-225 Medicaid Payment Accuracy Review Project - Minnesota

Project Officer: David McNally
Period: September 2001–September 2003
Awardee: Minnesota, Department of Human Services
Funding: $173,641

01-226 Medicaid Payment Accuracy Review Project - Mississippi

Project Officer: David McNally
Period: July 2001–September 2003
Awardee: Mississippi, Office of Governor, Division of Medicaid
Funding: $445,682

01-227 Medicaid Payment Accuracy Review Project - New York

Project Officer: David McNally
Period: September 2001–September 2003
Awardee: New York, Department of Health, (Albany)
Funding: $500,000

01-228 Medicaid Payment Accuracy Review Project - North Carolina

Project Officer: David McNally
Period: July 2001–June 2003
Awardee: North Carolina, Department of Health and Human Services
Funding: $220,296

01-229 Medicaid Payment Accuracy Review Project - North Dakota

Project Officer: David McNally
Period: July 2001–June 2003
Awardee: North Dakota
Funding: $29,011

01-230 Medicaid Payment Accuracy Review Project - Texas

Project Officer: David McNally
Period: September 2001–September 2003
Awardee: Texas, Health and Human Services Commission
Funding: $79,110

01-231 Medicaid Payment Accuracy Review Project - Washington

Project Officer: David McNally
Period: September 2001–September 2003
Awardee: Washington, Department of Social and Health Services
Funding: $112,324

01-232 Medicaid Payment Accuracy Review Project - Wyoming

Project Officer: David McNally
Period: July 2001–June 2003
Awardee: Wyoming, Department of Health
Funding: $37,224

00-040 Community Health Advocate Program

Project Officer: Joan Mahanes
Period: August 2000–November 2002
Awardee: Partners for a Healthier Community
Funding: $500,000

Description: This evaluation project examines the existing Community Health Advocate Program. The objective of the Program is to promote innovative strategies to use lay health workers in the role of Community Health Advocates to reach vulnerable populations. The evaluation studies the effects of community-based collaborations involving neighborhood-based non-profit organizations, State and local public health agencies, and a neighborhood-based health center on linking families and children to a medical home for routine primary health care. It identifies groups with unusual rates of disease, studies the association between suspected risk factors, and studies this association in populations with specific characteristics. The project also uses data from the State Immunization Registry and has the potential to increase knowledge about risk factors particular to the ethnic groups living in this community, and best practices for reaching similar populations who live in other communities.

Status: In progress.

00-126 Health Loop Information Project

Project Officer: Nancy Olsen
Period: September 2000–September 2003
Awardee: Shelby County Health Care Corporation, d/b/a Regional Medical Center at Memphis
Funding: $646,000

Description: This project merges a patient database with a Public Health Department's Patient Tracking System. The project includes staff training, software/hardware and licensing agreements required to operate the information in the Shelby County Health Care Network– "The Health Loop." The goal is to enable the Health Loop providers to provide more effective and efficient services by making primary care and public health patient information available through one information system.

Status: The grant was awarded in September 2000, and reports have been submitted quarterly. A final report is due in December 2001. A carryover of $225,000 was granted because Shelby County was moving into a different IT environment, and the old system would soon be obsolete.

00-083 Mauli Ola (Spirit of Life) Project

Project Officer: Mary Kapp
Period: September 2000–September 2005
Awardee: Waimanalo Health Center
Funding: $2,198,158

Description: Mauli Ola ("spirit of life") is an intensive and comprehensive community-wide outreach and preventive health program. It aims to increase positive motivators at both the individual and community levels through deliberate efforts to encourage individuals, families and the community to reassess and, where appropriate, recreate culturally relevant health and healing paradigms. Mauli Ola strategies include 1) culturally reinforced and medically sound outreach and health awareness; 2) health screening, early detection, and referral; and 3) health education, family nutrition, and exercise programs. The target population is the entire Waimanalo ahupua'a (a traditional Hawaiian integrated, self-sustaining, geographically-defined community), comprised largely of Native Hawaiians and other American Asian/Pacific Islanders, located in a rural agricultural area of southeast Oahu, Hawaii.

Status: In progress.

Nursing Home Transition Grant Initiative

This is a State-based grant program to assist the individual States in developing processes and infrastructure changes to transition individuals

currently in nursing homes to the community. States were encouraged to incorporate community-based attendant care services, which ensure maximum control, by the beneficiary in selecting and managing their care.

00-127 Pennsylvania Nursing Home Transition Grant 2000

Project Officer: Thomas Shenk
Period: September 2000–September 2003
Awardee: Pennsylvania, Department of Public Welfare
Funding: $500,000

Description: This project links the U.S. Department of Health and Human Services to work collaboratively with the State of Pennsylvania to enhance choices available to Medicaid beneficiaries who are currently residing in nursing homes. The goal is to empower consumers, promote consumer choice, and assist people to transition from nursing homes into the community. This project builds on the existing efforts in Pennsylvania to remove the bias toward the use of nursing facilities in the existing long-term care system. While much work to date has had a pre-admission focus, this project complements current efforts by assisting persons currently in nursing homes to return to the community. Existing service programs and waivers will fund the services needed in the community, and the project will pay for certain transitional needs that cannot be paid for with existing funding, such as deposits for housing and utilities or groceries. The State will evaluate the program to assist in the identification of barriers to returning to the community, either perceived or real, and will develop outcome measures so that the program can be evaluated for effectiveness and possibly replicated and/or continued beyond the terms of the Federal grant.

Status: This effort has now been incorporated into the "Real Choice System Change" projects that focus on the disabled.

99-097 Nursing Home Transition Initiative - New Hampshire

Project Officer: Thomas Shenk
Period: September 1999–September 2002
Awardee: New Hampshire, Department of Health and Human Services, (Pleasant St)
Funding: $499,460

Description: The New Hampshire Nursing Home Resident Choice Initiative is a pilot project to reorganize how long-term care is provided by developing new consumer-directed systems of providing care, as well as more flexible service/support options. It is anticipated that, in the first year, over 2,800 nursing home residents will be offered the opportunity to work with the consumer-directed independent service coordinator (ISC) and choose to return to the community. The State expects to transition 20 participants initially with others to follow. The project is developing and will utilize this new ISC model in two pilot geographic areas. All residents of nursing homes in these areas will be approached and offered the option to utilize the ISC. Together they will develop and implement a community-based care plan that reflects the consumer's goals and preferences. The ISC will work with the resident and his/her personal network to implement the community care plan. The ISC will then follow the individual to the community and continue to work as the agent for that individual in improving, monitoring, and coordinating the consumer's formal services, flexible benefits, and informal supports network in order to meet the desired outcomes of the consumer. The State will develop and make available several new services to the project participants. These include, in addition to the ISC services, access to innovative housing resources in collaboration with the State housing finance authority, community-based volunteer ombudsman services, emergency and crisis respite services by nursing facilities and provider networks, and transitional/bridge funding for transition to the community.

Status: The project was granted a no-cost extension for an additional year beyond the original termination date September 2000. The State has been submitting quarterly reports during the first year of operation.

00-129 Nursing Home Transition Grant - Arkansas Passages

Project Officer: Thomas Shenk
Period: September 2000–September 2002
Awardee: Arkansas, Department of Human Services
Funding: $500,000

Description: This project will assist a minimum of 80 persons to transition from nursing home to home care. The program will support staff, trained as independent services coordinators, from Independent Living Centers and the area agencies on aging to identify persons who have the desire to return home. A comprehensive assessment and detailed transition plan for returning to the home will be completed. Reimbursement to agencies for staff will be from grant funds. Transitional support services will provide payment for items, or services, to ensure the participant's environment is sufficient to promote a reasonable quality of life and independence. A selection of Medicaid State Plan services, waiver services and community resources will be available to assist the transitioning of each participant and will serve as the major source of funding for most services.

Status: This effort has now been incorporated into the "Real Choice System Change" projects that focus on the disabled.

00-130 Nursing Home Transition 2000 Program Grant: Partnership for Community Living

Project Officer: Thomas Shenk
Period: September 2000–September 2003
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr.)
Funding: $500,000

Description: This project targets Medicaid eligible individuals residing in nursing facilities, under the age of 55, who have sustained a traumatic brain injury and/or spinal cord injury. The goal is to transition individuals who choose to return to the community from nursing facilities by providing services and supporting unmet needs. Funding will help to expand current infrastructure for community-based supports and services, replicate the project with other disability groups, and sustain transitioned individuals in the community. Transition services include those not currently available, such as startup costs to secure housing, food, home modifications, and housing workshops and education. The project is a cooperative agreement between Florida, State and local agencies, and private organizations.

Status: This effort has now been incorporated into the "Real Choice System Change" projects that focus on the disabled.

01-254 Healthy Maine

Project Officer: Tammi Hessen
Period: September 2001–September 2002
Awardee: Maine, Department of Human Services
Funding: $0

Description: This is a Maine prescription drug discount program (operating under a waiver) for low- and moderate-income residents to use the Medicaid program to provide discounts to non-Medicaid-eligible individuals. The program covers 108,000 residents with incomes up to 300 percent of the Federal poverty level that are uninsured and not eligible for Medicaid. Essentially the State enrolls the recipients in the Medicaid program so that they are eligible for the same rebates or drug discounts that drug makers must offer State Medicaid programs. State officials estimate that up to 225,000 residents are eligible for the discounts, which can be as much as 25 percent off a drug's retail price.

Status: In late February 2002, a Federal judge rejected a pharmaceutical industry challenge (from the Pharmaceutical Research and Manufacturers of America) to the program, ruling that HHS had the authority to grant the State a waiver to use its Medicaid program to provide discounts to non-Medicaid-eligible individuals.

02-072 Assertive Community Treatment (ACT) and other Community-Based Services for Persons with Mental Illness or Persons with Co-Occurring Mental Illness and Substance Abuse Disorders

Project Officer: Peggy Clark
Period: July 2002–September 2003
Awardee: Lewin Group
Funding: $132,352

Description: Assertive Community Treatment (ACT) is a community-based psychosocial service intervention designed to provide comprehensive, multidisciplinary treatment to individuals who have severe and persistent mental illness. This task order will provide research, technical assistance, and guidance to States. The goal is to improve the understanding of existing options under Medicaid using both waivers and State plan services to improve access to community-based services, such as ACT, to children with an emotional disturbance ,and adults with mental illness or co-occurring mental illness and substance abuse or other disorders, as an alternative to a general hospital or nursing facility.

Status: This task order contract is a continuation and extension of previous work in Fiscal Year (FY) 1999-FY2001 under SAMHSA contract no. 282-98-0016, Task Order 19, which evaluated the implementation of evidence-based ACT programs in States and the use of Medicaid in financing such programs. The contract was modified in FY2001 to gain a better understanding of current barriers and facilitators to using the Medicaid Rehabilitation Option and the Targeted Case Management Option, as well as test the utility and efficacy of the Budget Simulation Model developed during the earlier phase of the project.

01-274 National Technical Assistance Exchange for Community Living - Independent Living Research Utilization

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Independent Living Research Utilization
Funding: $2,435,621

Description: This project sponsors work with Independent Living Research Utilization (ILRU) to develop, plan, and implement all technical assistance activities related to the Real Choice Systems Change projects. A single advisory group will provide feedback and input, and ensure that people with disabilities and long term illnesses are meaningfully involved in the activities undertaken as a result of grant funding. State agencies, providers, and other public and private partners are working to produce a Technical Assistance integrated Management and Operations plan.

Status: The project is newly underway.

01-275 National Technical Assistance Exchange for Community Living - Rutgers

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Rutgers' Center for State Health Policy
Funding: $2,435,621

Description: This project sponsors work with Independent Living Research Utilization (ILRU), to develop, plan, and implement all technical assistance activities related to the Real Choice Systems Change projects. A single advisory group will provide feedback and input, and ensure that people with disabilities and long term illnesses are meaningfully involved in the activities undertaken as a result of grant funding. State agencies, providers, and other public and private partners are working to produce a Technical Assistance integrated Management and Operations plan.

Status: The project is newly underway.

00-105 Measurable Outcomes of Nursing Home Initiative

Project Officer: Edward Mortimore
Period: September 2000–September 2002
Awardee: West Virginia Medical Institute
Funding: $849,131

Description: The purpose of this effort is to continue the preliminary work of CMS in analyzing changes in nursing home resident characteristics. The U.S. Senate Appropriations Committee requested an evaluation of the effect of the Nursing Home Initiative (NHI) on the quality of care in nursing homes. This project is designed to evaluate whether clinically important changes in resident status are occurring, and if so, any inferences that can be associated with the causes of those changes. However, this initiative is only part of a package of interventions intended to improve the quality of care in nursing homes and implemented at varying times and to varying degrees through out the U.S. Therefore, CMS has developed, over the previous several years, a set of databases that capture relevant variables about individuals living in Federally-certified nursing homes. These include, among others: the Minimum Data Set (MDS) system, the Outcome and Assessment Information Set (OASIS), and the Online Survey Certification and Reporting System (OSCAR). In combination, these data sets represent the largest longitudinal set of information ever collected on nursing home residents and nursing homes worldwide. CMS plans to use these data sets to measure and improve the quality of care in nursing homes. The data sets become the information source necessary to track changes in resident characteristics and services provided by nursing homes over time, and especially in response to CMS quality improvement initiatives. This project establishes a baseline (oriented in time to the opening of the MDS system) of resident conditions and services provided, and tracks changes in this baseline over time.

Status: The project has been extended for one year, to September 2002.

01-269 Logistics for Systems Change Grants for Community Living (SCGCL) and SCGCL Conference

Project Officer: Susan Hill
Period: June 2001–June 2002
Awardee: Conwal, Inc.
Funding: $450,000

Description: This project provides for logistical arrangements for grant review panels held in August 2001 and for a grantees' conference in December 2001.

01-174 System Change for Community Living - Offering of Informed Choices - Iowa

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Iowa, Department of Human Services
Funding: $1,025,000

Medicaid/State Children's Health Insurance Program (SCHIP) Eligibility Pilot

CMS is sponsoring demonstration projects in five States to identify new and effective ways to simplify the application and enrollment process for children eligible for Medicaid or remove barriers in the State Children's Health Insurance Program, a Federal-State partnership with (SCHIP) application and enrollment processes. SCHIP provides coverage for uninsured low-income children not eligible for Medicaid. Florida's project pilots an electronic application process targeted at Hispanic and Haitian children in day care centers. Incentives and application assistance fees will be offered to day care centers that assist families in completing electronic applications. A control group will also be established in which day cares will be offered a participation fee but will not assist families in completing applications electronically. The evaluative component focuses on pre- and post-intervention comparisons between control and intervention sites on variables such as the

rate of enrollment as a result of the project, denial rate, and reasons for denials. Information will also be collected about marketing the program to Hispanic and Haitian populations.

00-100 Medicaid/SCHIP Eligibility Pilot: Assisting the Young Uninsured in Daycare Organizations (AYUDO)

Project Officer: Candice Hall
Period: September 2000–June 2002
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
Funding: $80,000

Status: In progress.

00-104 Medicaid/SCHIP Eligibility Pilot: Cuyahoga County Income Self-Declaration Pilot

Project Officer: Candice Hall
Period: September 2000–January 2002
Awardee: Ohio, Department of Job and Family Services
Funding: $79,000

Status: The Ohio demonstration project pilots self-declaration of income in a limited geographic area for new applicants as well as re-determinations. One key question this project seeks to answer is whether self-declaration prevents families from becoming eligible because they misreport income and do not have the benefit of a worker auditing their statements against written verification. The evaluative component focuses on comparisons between persons who self-declare income with persons who provide verification of income and the impact this policy has on the perceptions of applicants about the application process.

00-101 MassHealth Member Express Renewal

Project Officer: Candice Hall
Period: September 2000–January 2002
Awardee: Massachusetts
Funding: $80,000

Status: Massachusetts's project focuses on simplifying the re-determination process. A simplified re-determination form will be developed, and self-declaration of income will be allowed at the re-determination. The pilot also will create the opportunity for families to complete the re-determination process at points of service, such as primary care providers' offices, and allow families to submit re-determination forms to extend 12-month continuous eligibility at any time during the current twelve-month period. Children enrolled six months or longer will be specifically targeted for submitting new re-determination forms. The evaluation component focuses on the impact these changes have on retention rates, continuity of care, and budget.

The Real Choice or Freedom Initiative Grants

The Real Choice or Freedom Initiative grants are designed to remove barriers to equality for the 54 million Americans living with disabilities. As a group, the projects continue to allow States to make meaningful changes in the lives of persons with disabilities. They help the individual State enable people with disabilities to reside in their own homes and participate fully in community life by designing and implementing improvements in community long-term support systems in partnership with the disability and aging communities. These systemic changes allow children and adults with disabilities or long-term illnesses to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements, and exercise more control over the providers of the services they receive.

02-040 Nursing Facility Transition Grant - South Carolina

Project Officer: Cathy Cope
Period: September 2002–September 2005
Awardee: South Carolina, Department of Health and Human Services
Funding: $600,000

02-046 Nursing Facility Transition Grant - Arkansas

Project Officer: Mary Frances Laverdure
Period: September 2002–September 2005
Awardee: Arkansas, Department of Human Services
Funding: $598,444

Status: This project is in the startup phase.

02-039 Nursing Facility Transition Grant – Delaware: Passport to Independence Program

Project Officer: Thomas Shenk
Period: September 2002–September 2005
Awardee: Delaware, Health and Social Services, (Dover)
Funding: $566,772

02-037 Nursing Facility Transition Grant - Nebraska: Creating Systems Change in the Transition Process Nebraska

Project Officer: Mary Clarkson
Period: September 2002–September 2005
Awardee: Nebraska, Department of Health and Human Services
Funding: $600,000

02-041 Nursing Facility Transition Grant - New Jersey: Young Adult Nursing Facility Resident Transition Initiative

Project Officer: Cathy Cope
Period: September 2002–September 2005
Awardee: New Jersey, Department of Health and Senior Services Division of Consumer Support, OLTCO, Community Choice Initiative
Funding: $600,000

02-049 Nursing Facility Transition Grant - Rhode Island: Transition to Independence

Project Officer: Thomas Shenk
Period: September 2002–September 2005
Awardee: Rhode Island, Department of Human Services
Funding: $600,000

02-050 Nursing Facility Transition Grant - North Carolina: Nursing Facility Transition Program

Project Officer: Mary Guy
Period: September 2002–September 2005
Awardee: North Carolina, Department of Health and Human Services
Funding: $600,000

02-042 Nursing Facility Transition Grant - Alabama

Project Officer: Maria Reed
Period: September 2002–September 2005
Awardee: Alabama, Medicaid Agency
Funding: $770,000

01-196 Nursing Facility Transitions - State Program Grant - Washington

Project Officer: Andrew Mack
Period: September 2001–September 2004
Awardee: Washington, Aging and Adult Services Administration
Funding: $770,000

Status: This particular project will help the State of Washington transition eligible individuals from nursing facilities to the community.

01-165 Nursing Facility Transitions - State Program Grant - Indiana

Project Officer: Linda Abbott
Period: September 2001–September 2004
Awardee: Indiana, Family and Social Services Administration
Funding: $770,000

01-164 Nursing Facility Transitions - State Program Grant - Massachusetts

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Massachusetts, Department of Mental Retardation
Funding: $770,000

01-172 Research on System Change for Community Living

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2006
Awardee: Research Triangle Institute, (DC)
Funding: $1,899,996

Description: The goal of this project is to conduct both formative and summative evaluation of the System Change for Community Living grant program. This project will capture relevant data about the: target populations selected; specific long term care needs; similarities and differences between methods; challenges and barriers; changes made in the provision of long term care as a result of the activities; and factors influencing environments. The project will also establish the initial framework and foundation for future summative evaluation activities.

Status: This project is in year 2.

NURSING FACILITY TRANSITIONS - INDEPENDENT LIVING PARTNERSHIP

The Real Choice or Freedom Initiative grants are designed to remove barriers to equality for the 54 million Americans living with disabilities. These particular projects will help States transition eligible individuals from nursing facilities to the community through grants to support "Independent Living Partnership" to selected Independent Living Centers (ILCs). These grants will promote partnerships between ILCs and States to support nursing facility transitions. They will help the individual State enable people with disabilities to reside in their own homes and participate fully in community life. This will happen by designing and implementing improvements in community long-term support systems in partnership with the disability and aging communities. These systemic changes will allow children and adults with disabilities or long term illnesses to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements, and exercise more control over the providers of the services they receive.

01-199 Nursing Facility Transitions - Independent Living Partnership - Alabama

Project Officer: Tammi Hessen
Period: September 2001–September 2004
Awardee: Mid Alabama Chapter of the Alabama Coalition of Citizens with Disabilities
Funding: $450,000

Status: This particular project will help the State of Alabama transition eligible individuals from nursing facilities to the community through grants to support "Independent Living Partnership" to selected ILCs.

01-200 Nursing Facility Transitions - Independent Living Partnership - Georgia

Project Officer: Andrew Mack
Period: September 2001–September 2004
Awardee: DisABILITY LINK
Funding: $400,000

Status: This particular project will help the State of Georgia transition eligible individuals from nursing facilities to the community through grants to support "Independent Living Partnership" to ILCs.

01-201 Nursing Facility Transitions - Independent Living Partnership -Texas

Project Officer: Linda Abbott
Period: September 2001–September 2004
Awardee: ARCIL, Inc.
Funding: $308,178

Status: This particular project will help the State of Texas transition eligible individuals from nursing facilities to the community through grants to support "Independent Living Partnership" to selected ILCs.

01-202 Nursing Facility Transitions - Independent Living Partnership - Wisconsin

Project Officer: Melissa Harris
Period: September 2001–September 2004
Awardee: Great Rivers Independent Living Services, Inc.
Funding: $450,000

Status: This particular project will help the State of Wisconsin transition eligible individuals from nursing facilities to the community through grants to support "Independent Living Partnership" to selected ILCs.

Real Choice Systems Change "Starter Grant"

The Real Choice Systems Change "Starter Grant" program helps States develop plans for improving their long-term support systems for community living, includes people with disabilities or long-term illness in the planning processes, and prepares for other forthcoming grant opportunities. Starter grants are made available to all States and Territories to support programs that enable people with disabilities or long term illness to reside in their own homes and participate fully in their communities. The grant is one way CMS assists States with "up-front" expenses such as organizing or supporting a consumer task force or a public-private partnership.

01-070 Real Choice Systems Change "Starter Grant" - American Samoa

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: American Samoa, Department of Commerce
Funding: $50,000

Status: This is a standard award to allow the recipient to begin the activities that will lead to later project[s].

01-091 Real Choice Systems Change "Starter Grant" - Guam

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Guam, Developmental Disabilities Council
Funding: $50,000

Status: The project was extended through December 2002.

01-064 Real Choice Systems Change "Starter Grant" - Kansas

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Kansas, Department of Social and Rehabilitation Services
Funding: $50,000

Status: This is a standard award to allow the recipient to begin the activities that will lead to later project[s].

01-095 Real Choice Systems Change "Starter Grant" - Minnesota

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Minnesota, Department of Human Services
Funding: $50,000

Status: The project has been extended through December 2002.

01-054 Real Choice Systems Change "Starter Grant"- North Carolina

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: North Carolina, Department of Health and Human Services
Funding: $50,000

Status: The project has been extended through December 2002.

01-075 Real Choice Systems Change "Starter Grant" - Ohio

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Ohio, Department of Job and Family Services
Funding: $50,000

Status: The project has been extended through December 2002.

01-080 Real Choice Systems Change "Starter Grant" - Pennsylvania

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Pennsylvania, Department of Public Welfare
Funding: $50,000

Status: The project has been extended through December 2002.

01-090 Real Choice Systems Change "Starter Grant" - Texas

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Texas, Health and Human Services Commission
Funding: $50,000

Status: The project has been extended through December 2002.

01-088 Real Choice Systems Change "Starter Grant" - Virginia

Project Officer: Mary Guy
Period: February 2001–December 2002
Awardee: Virginia, Department of Medical Assistance Ser5vices
Funding: $50,000

Status: The project has been extended through December 2002.

01-106 Real Choice Systems Change "Starter Grant" - Wyoming

Project Officer: Mary Guy
Period: February 2001–February 2002
Awardee: Wyoming, Department of Health
Funding: $50,000

Status: The project was extended through December 2002.

Nursing Facility Transitions - State Program Grant

The Real Choice or Freedom Initiative grants are designed to remove barriers to equality for the 54 million Americans living with disabilities. As a group, the projects continue to allow States to make meaningful changes in the lives of persons with disabilities. They help the individual State enable people with disabilities to reside in their own homes and participate fully in community life by designing and implementing improvements in community long-term support systems in partnership with the disability and aging communities. These systemic changes allow children and adults with disabilities or long-term illnesses to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements, and exercise more control over the providers of the services they receive.

01-157 Nursing Facility Transitions - State Program Grant - Alaska

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Alaska, Department of Administration
Funding: $800,000

Status: This project award is in the startup phase.

01-162 Colorado Transition Project

Project Officer: Deondra Moseley
Period: September 2001–September 2004
Awardee: Colorado, Department of Health Care Policy and Financing
Funding: $800,000

Status: This project award is in the startup phase.

01-178 Nursing Facility Transitions - State Program Grant - Connecticut

Project Officer: Melissa Harris
Period: September 2001–September 2004
Awardee: Connecticut, Department of Social Services
Funding: $800,000

Status: This particular project will help the State of Connecticut transition eligible individuals from nursing facilities to the community. As a group, the projects will allow States to make meaningful changes in the lives of persons with disabilities.

01-158 Nursing Facility Transitions - State Program Grant - Georgia

Project Officer: Andrew Mack
Period: September 2001–September 2004
Awardee: Georgia, Department of Community Health
Funding: $6,272,111

Status: This project award is in the startup phase.

01-159 Nursing Facility Transitions - State Program Grant - Maryland

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Maryland, Department of Human Resources
Funding: $800,000

Status: This project award is in the startup phase.

01-176 Nursing Facility Transitions - State Program Grant - Michigan

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Michigan, Department of Community Health
Funding: $770,000

Status: This particular project will help the State of Michigan transition eligible individuals from nursing facilities to the community. As a group, the projects will allow States to make meaningful changes in the lives of persons with disabilities.

01-195 Nursing Facility Transitions - State Program Grant - New Hampshire

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: New Hampshire, Department of Health and Human Services, (Pleasant St)
Funding: $770,000

Status: This particular project will help the State of New Hampshire transition eligible individuals from nursing facilities to the community.

01-197 Nursing Facility Transitions - State Program Grant - West Virginia

Project Officer: Tammi Levy-Cantor
Period: September 2001–September 2004
Awardee: West Virginia, Department of Health and Human Resources, Bureau for Medical Services
Funding: $551,678

Status: This particular project will help the State of West Virginia transition eligible individuals from nursing facilities to the community.

The Real Choice or Freedom Initiative Grants

The Real Choice or Freedom Initiative grants are designed to remove barriers to equality for the 54 million Americans living with disabilities. Each particular project will help the State design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities. As a group, the projects allow States to make meaningful changes in the lives of persons with disabilities, and enable people with disabilities to reside in their own homes and participate fully in community life. This will happen by designing and implementing improvements in community long-term support systems in partnership with the disability and aging communities. These systemic changes will allow children and adults with disabilities or long-term illnesses to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements, and exercise more control over the providers of the services they receive.

01-155 Real Choice Systems Change Grant - Alabama

Project Officer: Tammi Hessen
Period: September 2001–September 2004
Awardee: Alabama, Medicaid Agency
Funding: $2,000,000

Status: This project award is in the startup phase.

01-163 Real Choice Systems Change Grant - Arkansas

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Arkansas, Department of Human Services
Funding: $1,025,000

Status: This project award is in the startup phase.

01-173 **Real Choice Systems Change Grant - Delaware**

Project Officer: Donna Wenner
Period: September 2001–September 2004
Awardee: Delaware, Health and Social Services, (Dover)
Funding: $1,200,000

Status: This particular project will help the State of Delaware to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-161 **Real Choice Systems Change Grant - Florida**

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Florida, Department of Management Services
Funding: $2,000,000

Status: This project award is in the startup phase.

01-152 **Real Choice Systems Change Grant - Guam**

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Guam, Department of Public Health and Social Services
Funding: $673,106

Status: This project award is in the startup phase.

01-153 **Real Choice Systems Change Grant - Hawaii**

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Hawaii, Department of Human Services
Funding: $1,350,000

Status: This project award is in the startup phase.

01-160 **Real Choice Systems Change Grant - Idaho**

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Idaho, Department of Health and Welfare, (State St)
Funding: $1,102,148

Status: This project award is in the startup phase.

01-154 **Real Choice Systems Change Grant - Illinois**

Project Officer: Patricia Helphenstine
Period: September 2001–September 2004
Awardee: Illinois, Department of Human Services
Funding: $800,000

Status: This project award is in the startup phase.

01-194 **Real Choice Systems Change Grant - Kentucky**

Project Officer: Tammi Hessen
Period: September 2001–September 2004
Awardee: Kentucky, Cabinet for Health Services
Funding: $2,000,000

Status: This particular project will help the State of Kentucky to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-204 Real Choice Systems Change Grant - Maine

Project Officer: Tammi Hessen
Period: September 2001–September 2004
Awardee: Maine, Department of Human Services
Funding: $2,300,000

Status: This particular project will help the State of Maine to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-187 Real Choice Systems Change Grant - Maryland

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Maryland
Funding: $1,025,000

Status: This particular project will help the State of Maryland to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-205 Real Choice Systems Change Grant - Massachusetts

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: University of Massachusetts Medical School
Funding: $1,025,000

Status: This particular project will help Massachusetts design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long term illnesses to live and participate in their communities.

01-206 Real Choice Systems Change Grant - Michigan

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Michigan, Department of Community Health
Funding: $2,000,000

Status: This particular project will help the State of Michigan to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-208 Real Choice Systems Change Grant - Minnesota

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Minnesota, Department of Human Services
Funding: $2,300,000

Status: This particular project will help the State of Minnesota to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-209 Real Choice Systems Change Grant - Missouri

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Missouri, Department of Social Services
Funding: $2,000,000

Status: This particular project will help the State of Missouri to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-207 Real Choice Systems Change Grant - Nebraska

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Nebraska, Department of Health and Human Services
Funding: $2,000,000

Status: This particular project will help the State of Nebraska to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long term illnesses to live and participate in their communities.

01-203 Real Choice Systems Change Grant - New Hampshire

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: New Hampshire, Department of Health and Human Services, (Pleasant St)
Funding: $2,300,000

Status: This particular project will help the State of New Hampshire to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-182 Real Choice Systems Change Grant - New Jersey

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: New Jersey, Department of Human Services
Funding: $2,000,000

Status: This particular project will help the State of New Jersey to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-175 Real Choice Systems Change Grant - North Carolina

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: North Carolina, Department of Health and Human Services
Funding: $1,600,000

Status: This particular project will help the State of North Carolina to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-184 Real Choice Systems Change Grant - Oregon

Project Officer: Patricia Helphenstine
Period: September 2001–September 2004
Awardee: Oregon, Department of Human Services
Funding: $2,000,996

Status: This particular project will help the State of Oregon to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-177 Real Choice Systems Change Grant - South Carolina

Project Officer: Mary Clarkson
Period: September 2001–September 2004
Awardee: South Carolina, Department of Health and Human Services
Funding: $2,300,000

Status: This particular project will help the State of South Carolina to design and implement effective and enduring improvements in community long term support systems to enable children and adults of any age who have disabilities or long term illnesses to live and participate in their communities.

01-179 Real Choice Systems Change Grant - Tennessee

Project Officer: Cathy Cope
Period: September 2001–September 2004
Awardee: Tennessee, Department of Mental Health and Developmental Disabilities
Funding: $1,768,604

Status: This particular project will help the State of Tennessee to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-180 Real Choice Systems Change Grant - Vermont

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Vermont, Agency of Human Services
Funding: $2,000,000

Status: This particular project will help the State of Vermont to design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have disabilities or long-term illnesses to live and participate in their communities.

01-156 Real Choice Systems Change Grant - Virginia

Project Officer: Mary Clarkson
Period: September 2001–September 2004
Awardee: Virginia, Department of Medical Assistance Ser5vices
Funding: $1,025,000

Status: This project award is in the startup phase.

01-181 Community-Integrated Personal Assistance Services and Supports - Alaska

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Alaska, Department of Administration
Funding: $90,000

Status: This particular project will help the State of Alaska support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-193 Community-Integrated Personal Assistance Services and Supports - Arkansas

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Arkansas, Department of Human Services
Funding: $900,000

Status: This particular project will help the State of Arkansas support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-183 Community-Integrated Personal Assistance Services and Supports - Guam

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Guam, Department of Integrated Services for Individuals with Disabilities
Funding: $300,000

Status: This particular project will help the Trust Territory of Guam support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-174 System Change for Community Living - Offering of Informed Choices - Iowa

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Iowa, Department of Human Services
Funding: $1,025,000

Status: This particular project will help the State of Iowa support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-185 Community-Integrated Personal Assistance Services and Supports - Michigan

Project Officer: Karen Tritz
Period: September 2001–September 2004
Awardee: Michigan, Department of Community Health
Funding: $755,972

Status: This particular project will help the State of Michigan support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-186 Community-Integrated Personal Assistance Services and Supports - Minnesota

Project Officer: Mary Guy
Period: September 2001–September 2004
Awardee: Minnesota, Department of Human Services
Funding: $900,000

Status: This project award is in the startup phase.

01-188 Community-Integrated Personal Assistance Services and Supports - Montana

Project Officer: Patricia Helphenstine
Period: September 2001–September 2004
Awardee: Montana, Department of Public Health and Human Services
Funding: $850,000

Status: This particular project will help the State of Montana support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-190 Community-Integrated Personal Assistance Services and Supports - Nevada

Project Officer: Mary Clarkson
Period: September 2001–September 2004
Awardee: Nevada, Department of Employement, Training and Rehabilitation
Funding: $655,988

Status: This particular project will help the State of Nevada support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-189 Community-Integrated Personal Assistance Services and Supports - New Hampshire

Project Officer: Mary Frances Laverdure
Period: September 2001–September 2004
Awardee: Granite State Independent Living
Funding: $900,000

Status: This particular project will help the State of New Hampshire support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-191 Community-Integrated Personal Assistance Services and Supports - Oklahoma

Project Officer: Donna Wenner
Period: September 2001–September 2004
Awardee: Oklahoma, Department of Human Services
Funding: $850,000

Status: This particular project will help the State of Oklahoma support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-192 Community-Integrated Personal Assistance Services and Supports - Rhode Island

Project Officer: Donna Wenner
Period: September 2001–September 2004
Awardee: Rhode Island, Department of Human Services
Funding: $539,730

Status: This particular project will help the State of Rhode Island support efforts to improve personal assistance services that are consumer-directed or offer maximum individual control.

01-150 Increasing Access to Health Care for Buck's County Residents

Project Officer: Carol Magee
Period: September 2001–September 2004
Awardee: Bucks County Health Improvement Project, Inc.
Funding: $1,843,000

Description: The project is entirely directed toward increasing access to health care for targeted vulnerable populations. Five of the Buck's County Health Improvement Project (BCHIP) 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.

Status: The project is in the developmental stage.

01-169 Health Passport Project

Project Officer: Sydney Galloway
Period: September 2001–September 2003
Awardee: Western Governor's Association
Funding: $500,000

Description: This project is to design, test, and evaluate the use of hybrid card technology, public kiosks, and the internet as vehicles for public health programs to securely share client health data. The awardee considers the project an ongoing field demonstration in Cheyenne, Wyoming; Bismarck, North Dakota; and Reno, Nevada. It provides a versatile, multi-purpose electronic card to streamline access to and delivery of a variety of public and private health services and benefit services for lower income working families. The idea of a common identification and information card for a series of social programs is cognitively attractive. The governments of the presently cooperating States also demonstrate this by their willingness to participate. The possibility that the State of California will also participate expands the Federal interest because this approach could well become a functioning reality. The one-time award is divided across two phases: The first provides partial support of a project that is already underway; the second is for the later expansion.

Status: Phase I: Three Health Passport demonstration cities will complete the pilot phase on December 2001. An evaluation report will be released in January 2002.

Phase II: The target date to issue the first smart cards is August 2002.

01-117 Health Technology Improvement: Testing the Acceptability of Using Electronic Data Interchange Among Traditional and Safety Net Providers in Los Angeles County

Project Officer: Nancy Olsen
Period: September 2001–September 2002
Awardee: Los Angeles Care Health Plan
Funding: $250,000

Description: This is a technology assessment and improvement project among traditional and safety net providers in Los Angeles County. The primary goal is to increase electronic clinical and business practices through Electronic Data Interchange. Within the health care delivery system, information technology is considered a prerequisite to integrated high quality care. The shift to Medicaid managed care through the country has intensified the demand for information systems that can generate the data necessary to track eligibility/enrollment, measure quality, monitor costs, submit claims, and obtain authorizations and more. Survival for the traditional and safety net provider in the current health care techno-culture requires an understanding and investment information technology. Traditional and safety net providers dedicated to serving low-income communities are not able to invest in the improvement of information technology due to limited resources.

Status: This project is underway.

02-068 Evaluation of the Development and Early Implementation of Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative

Project Officer: Theresa Sachs
Period: September 2002–September 2003
Awardee: Urban Institute
Funding: $353,667

Description: This evaluation will study the impact that section 1115 research and demonstration authority has on the process that States go through in order to obtain approval of their demonstrations. Many States have used this authority under Medicaid and the State Children's Health Insurance Program (SCHIP) to expand eligibility, thereby reducing the number of uninsured. HIFA provides clear guidelines for States to use 1115 authority and expedite review for States applying for a HIFA demonstration.

Status: As of June 21, 2002 two States have projects that have been approved under HIFA and eight States have proposals that are currently being reviewed. All the material for the approved and pending HIFA demonstrations are available on the CMS website at www.cms.hhs.gov/medicaid/hifa/default.htm.

82-001 Arizona Health Care Cost Containment System

Project Officer: Joan Peterson
Period: July 1982–September 2006
Awardee: Arizona Health Care Cost Containment System
Funding: $0

Description: The Arizona Health Care Cost Containment System (AHCCCS) began operation on October 1, 1982, and initially covered only acute-care services. The Arizona Long-Term Care System component was implemented in 1988. A phase-in of comprehensive behavioral health services began in 1990, and was completed in 1995. The demonstration has been extended on several occasions, most recently through September 2006. In January 2001, CMS approved an expansion to increase eligibility for the acute care program to 100 percent of the Federal poverty level (FPL). This expansion was phased in beginning April 1, 2001, and is projected to add 187,000 enrollees. In addition, Arizona received approval of an amendment under the Health Insurance Flexibility and Accountability (HIFA) initiative on December 12, 2001. This amendment covers single adults and childless couples with income at or below 100 percent FPL and parents of Medicaid and State Children's Health Insurance Program (SCHIP) children with income between 100 percent and 200 percent FPL. Approximately 646,000 persons are currently enrolled in the program.

Status: The Arizona Health Care Cost Containment System (AHCCCS) began operation on October 1, 1982, and initially covered only acute-care services. The Arizona Long-Term Care System component was approved as part of a 5-year extension of the AHCCCS demonstration from 1988 through 1993. A phase-in of comprehensive behavioral health services began in 1990, and was completed in 1995. The demonstration has been extended on several occasions, most recently through September 30, 2002. On January 18, 2001, HCFA approved an expansion to increase eligibility for the acute care program to 100 percent of the Federal poverty level. This expansion will be phased in beginning April 1, 2001, and is projected to add 187,000 enrollees. Approximately 506,000 persons are currently enrolled in the program.

94-128 Kentucky Health Care Partnership Plan Amendment

Project Officer: Maria Boulmetis
Period: October 1995–October 2002
Awardee: Kentucky, Department for Medicaid Services
Funding: $0

Description: Kentucky did not receive the necessary State legislation to implement the Kentucky Medicaid Access and Cost Containment demonstration, approved on December 9, 1993. On June 19, 1995, the State submitted an amendment to its proposal, entitled the Kentucky Health Care Partnership Plan. The amendment divided the State into eight regional managed care networks, consisting of public and private providers to deliver health care services to Medicaid beneficiaries. The design of each region was to have one managed care entity subject to State-specified guidelines. Medicaid beneficiaries are enrolled into the Partnership designated for their area. In areas where a viable partnership cannot be established, the State planned to invite two or more health maintenance organizations to competitively bid for the managed care contract.

In January 2000, the State informed CMS that one of the two operating managed care entities had voluntarily decided to terminate its contract. This left only one area operational because the State had not expanded the demonstration statewide. This area is the State's largest urban area, which includes the city of Louisville in Jefferson County and 15 surrounding counties, comprising 20 percent of the State's Medicaid population.

Status: The State has submitted an amendment to convert the demonstration to a sub-State model and be at risk for waiver costs only for areas where the demonstration remains implemented. That amendment is under review.

97-024 Evaluation of the Ohio Behavioral Health Program

Project Officer: Penelope Pine
Period: September 1997–September 2002
Awardee: Health Economics Research
Funding: $579,216

Description: The evaluation was designed to assess the effect of Ohio's Specialty Managed Care for Behavioral Health Services Program on the delivery of behavioral health services. It was to address: 1) the program's effect on coordination and continuity of care among behavioral health services and between behavioral and physical health services; 2) the accountability for treatment decisions and appeals; 3) the program's effect on access to care; 4) the program's effect on quality of care, including process of care, satisfaction with care, functional status, and health status; 5) the program's effect on the use and cost of services; and shifting between systems, duplication of services, or duplication of payments.

Status: Because the original behavioral health services program cannot be implemented, the project will focus on a market analysis of managed care providers.

95-021 Vermont Health Access Plan (VHAP)

Project Officer: Joan Peterson
Period: January 1996–December 2003
Awardee: Vermont, Agency of Human Services
Funding: $0

Description: Vermont's section 1115 Medicaid demonstration makes comprehensive health care coverage available to individuals, including those currently eligible for coverage under Vermont's Medicaid program, and uninsured poor who become newly eligible. VHAP implements a statewide mandatory Medicaid managed-care program. The program began on January 1, 1996, and will operate for 8 years. The demonstration provides health care services to uninsured lower-income Vermonters (up to 300 percent of the Federal Poverty Level (FPL) for children and up to 185 percent of the FPL for parents and caretakers of eligible children). It also provides a Medicaid prescription-drug benefit to the State's lower-income Medicare beneficiaries. Finally, it improves access, service coordination, and quality of care through the implementation of a managed-care delivery system.

Status: As of December 2001, there were approximately 81,000 enrollees.

96-009 Maryland Medicaid Section 1115 Health Care Reform Demonstration Proposal–HealthChoice

Project Officer: Linda Welle
Period: October 1996–June 2002
Awardee: Maryland, Department of Health and Mental Hygiene
Funding: $0

Description: This statewide demonstration was developed to: 1) provide a patient-focused system; 2) build on the strengths of the current Maryland health care system; 3) provide comprehensive, prevention-oriented systems of care; 4) hold managed-care organizations (MCOs) accountable for high-quality

care; and 5) achieve better value and predictability for State expenditures. Maryland enrolls all waiver eligibles into an MCO for care and uses a case management system. Mental-health services are provided under the demonstration in a separate fee-for-service delivery system.

Status: The demonstration was implemented in June 1997 and is approved until May 2005.

93-038 Oregon Reform Demonstration

Project Officer: Juli Harkins
Period: April 1993–January 2002
Awardee: Oregon, Department of Human Services
Funding: $0

Description: The Oregon Reform Demonstration is an innovative program of managed care and a restructured Medicaid benefit package covering both the Medicaid-eligible and the uninsured populations. The demonstration extends Medicaid eligibility for Oregonians whose income is below the Federal poverty level, regardless of age, sex, and family status. Since the number of persons eligible for benefits is substantially increased, Oregon is implementing two mechanisms for containing costs: prioritization of condition-specific treatments and procedures that will be included in the Medicaid benefit package, and managed-care initiatives to enhance coordination of care and provide incentives for controlling costs. Mental-health and chemical-dependence services were incorporated into the Oregon Health Plan (OHP) benefit package for up to 25 percent of the eligible population with the implementation of Phase II in January 1995 and added for the rest of the population in July 1997. In March 1995, Phase II eligibles, which include aged, blind, disabled, and foster-care children, were added to the OHP. Nursing facilities and home and community-based services will not be affected by the demonstration.

Status: The demonstration authority expires January 2002. Oregon has submitted an extension request to CMS to continue the demonstration from February 2002 to January 2005. There were about 260,000 enrollees as of November 2001.

97-266 The Partnership Plan

Project Officer: Cheryl Tarver
Period: July 1997–March 2003
Awardee: New York, Department of Health, (Albany)
Funding: $0

Description: The Partnership Plan will move approximately 2.1 million Medicaid beneficiaries from a primarily fee-for-service delivery system to a managed care environment. The demonstration incorporates two other broad initiatives: the development of Special Needs Plans (SNPs) to serve certain sub-populations that require intensive and heavily case-managed care regimens; and the conversion of the State's 370,000 Home Relief recipients, a State-funded cash assistance program for low-income adults who are not otherwise eligible for TANF or Medicaid.

Status: Implementation on a county-by-county basis began on October 6, 1997. As of October 1999, thirteen counties have begun to implement the waiver. These counties are: Albany, Broome, Columbia, Erie, Greene, Monroe, Niagara, Onondaga, Ontario, Rensselaer, Saratoga and Oswego, and Westchester. Schenectady County has been approved, but not yet begun enrolling Medicaid beneficiaries into managed care. On July 30, 1999 CMS granted approval to implement the Partnership Plan in Phase 1 of New York City; Staten Island, lower Manhattan, and parts of Brooklyn.

98-201 ARKids B

Project Officer: Joan Peterson
Period: September 1997–August 2002
Awardee: Arkansas, Department of Human Services
Funding: $0

Description: The ARKids B demonstration (renamed from ARKids First in August 2000) expands eligibility to currently uninsured children through age 18 with family income at or below 200 percent of the Federal poverty level. 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. Arkansas' existing section 1915(b) waiver program, ConnectCare, continues to operate as a separate program, enrolling applicants who meet current Medicaid eligibility requirements. ARKids B operates as a fee-for-service, primary care case management model. It employs the ConnectCare provider network currently in place for the section 1915(b) program.

Status: This demonstration was implemented in September 1997. As of December 2001 there were 58,000 enrollees.

96-007 Medicaid Demonstration Project for Los Angeles County

Project Officer: Cheryl Tarver
Period: July 1996–June 2005
Awardee: California, Department of Health Services
Funding: $0

Description: This is a 5-year, budget-neutral demonstration intended to provide fiscal relief to the County, stabilize the public health system, and assist the process of restructuring the County's health care delivery system to rely more on primary and outpatient care. The amendment proposes to expand children's access to health services by including school-based clinics as ambulatory care providers under the demonstration.

Status: CMS provided questions/comments to the State on this amendment on September 17, 1999. On October 13, 1999, CMS received the State's extension proposal, as the approved demonstration expires on June 30, 2000. The Department of Health and Human Services is actively reviewing the extension proposal.

98-272 New Jersey Managed Charity Care

Project Officer: Daniel McCarthy
Period: February 1998–February 2003
Awardee: New Jersey, Department of Human Services
Funding: $0

Description: Under this demonstration, the State planned to use a portion of current disproportionate share hospital (DSH) funds to cover medical costs of indigent individuals provided outside of the hospital. Hospitals would be required to develop what the State calls "Hospital-Centered Managed Care Networks," which would deliver case-managed care to certain indigent individuals outside of the hospital, in physicians' offices and community clinics, in addition to the emergency and inpatient care currently provided.

Status: Due to legislative action in New Jersey, this proposed demonstration is "on hold." The State will be proposing a revised approach.

94-104 Rhode Island RIte Care, Department of Human Services

Project Officer: Alisa Adamo
Period: August 1994–July 2002
Awardee: Rhode Island, Department of Human Services
Funding: $0

Description: This statewide initiative, approved in November 1993, seeks to increase access to and delivery of primary and preventive health care services for all Aid to Families with Dependent Children recipients (65,000) and to extend coverage to approximately 4,000 pregnant women and children under 8 years of age, with family incomes up to 250 percent of the Federal poverty level (FPL). RIteCare eligibles are required to enroll in prepaid health plans contracted with the State to provide comprehensive health services. Prepaid health plans offer medical and mental-health benefits. Long-term-care services are not provided through the plans. Plans are required to offer participants a package of enhanced

services to assist in overcoming the nonfinancial barriers to care, including home visits, nutrition counseling, childbirth education, parenting skills education, and smoking cessation. Pregnant women enrolled in RIteCare who lose eligibility 60 days postpartum are offered the opportunity to enroll in an extended family-planning program for a 2-year period. RIteCare included a cost-sharing component. Individuals with incomes of between 185 and 250 percent of the FPL (new eligibles) are subject to cost-sharing requirements, either through premiums or copayment arrangements. Individuals with incomes of less than 185 percent of the FPL are not subject to any cost-sharing requirements.

Status: Enrollment in this program began August 1994. At the end of December 1998, over 75,500 eligible women and children had been enrolled in managed-care plans. Approximately 4,500 of these enrollees are included as a result of the demonstration waivers. The waiver population now includes children up to the age of 18 with family incomes up to 250 percent of the FPL. The demonstration has been extended through July 2002.

93-062 Hawaii QUEST

Project Officer: Maria Boulmetis
Period: April 1994–March 2002
Awardee: Hawaii, Department of Human Services
Funding: $0

Description: Hawaii QUEST is a statewide project that creates a public purchasing pool that arranges for health care through capitated managed-care plans. Hawaii QUEST builds on Hawaii's Prepaid Health Care Act by integrating public and private programs to develop a more efficient, seamless health care delivery system for individuals previously served by three public programs: Medicaid, General Assistance, and the State Health Insurance Program. The project initially extended the Medicaid eligibility income limits to 300 percent of the Federal poverty level (FPL). However, the income limits have since been reduced due to budgetary constraints. Most individuals are eligible through 100 percent of FPL, though pregnant women and infants under age 1 are eligible up to 185 percent of FPL and children ages 1 to 6 are eligible up to 133 percent of FPL. The program provides a benefit package consistent with the services currently offered under Hawaii's traditional Medicaid program, including medical, dental, and behavioral health services.

Status: The State has submitted an amendment to enroll children who become ineligible for the State Children's Health Insurance Program because their family income exceeds 200 percent of FPL, but the income is still below 300 percent FPL. The amendment is under review.

99-134 New Mexico Health Care Reform Demonstration

Project Officer: Maurice Gagnon
Period: January 1999–December 2004
Awardee: New Mexico, Department of Human Services, Medical Assistance Division
Funding: $0

Description: This demonstration allows the State to implement its Title XXI (SCHIP) Medicaid expansion to cover children in families through age 18 with incomes between 186 percent and 235 percent of the Federal poverty level, including co-payment requirements for this population. The State anticipates that a Medicaid program with cost sharing for the SCHIP population will approach parity with privately covered families in the same income grouping. Co-payments will apply in both fee-for-service and managed care environments. The demonstration would operate concurrently with its existing 1915(b) freedom of choice waiver.

Status: New Mexico's demonstration has been approved and implemented by the State.

98-273 Missouri Managed Care Plus (MC+)

Project Officer: Nancy Goetschius
Period: April 1998–December 2003
Awardee: Missouri, Department of Social Services, Division of Medical Assistnace
Funding: $0

Description: The demonstration expands eligibility to working parents who are transitioning from welfare and who have a Medicaid eligible child in the home, to absent parents who are participating in Missouri's Parent's Fair Share program with incomes up to 100 percent of the Federal poverty level (FPL), and to absent parents with incomes up to 125 percent of the FPL who are actively paying their legally obligated amount of child support. The State will lock in these expansion eligible Medicaid beneficiaries for 1 year in their managed care delivery system, MC+. Together, the Section 1115 demonstration, the Section 1915(b) waiver, and the Title XXI plan provide Medicaid managed care to all eligible adults and children in the State with incomes to 300 percent of the FPL.

Status: In January 1999 a modification to the Section 1115 demonstration was approved that allows the State to disenroll adults and children who show a pattern (four or more) of failing to pay the co-payment requirements. In February 1999 a modification was approved to allow the State to expand eligibility to uninsured noncustodial adults with incomes up to 125 percent of the FPL. The modification was requested because the State legislature had mandated the increased eligibility income level from 100 percent to the approved 125 percent for this population of adults.

95-052 Evaluation of the State Medicaid Reform Demonstrations, II

Project Officer: Paul Boben
Period: September 1995–September 2002
Awardee: Urban Institute
Funding: $5,959,408

Description: This is an evaluation of Medicaid demonstrations in five States: California (Medicaid Demonstration for Los Angeles County), Kentucky (Kentucky Health Care Partnership Plan), Minnesota (PMAP+), New York (Partnership Plan), and Vermont (Vermont Health Access Plan). The project includes State-specific and cross-State analyses of demonstration impacts on use of services, insurance coverage, public and private expenditures, quality of care, access and satisfaction. Data will come from site-visit interviews with providers, advocacy groups, and State officials; participant surveys; State Medicaid Management Information Systems; and other sources. Additional analyses are planned that focus on the effect of managed care on the receipt of mental-health services by Medicaid recipients. Funding for this additional work is from the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Status: The following project milestones occurred in 2001. 1) Post-managed care implementation surveys were completed in Minnesota. 2) The final site visit was conducted in Los Angeles County, California. 3) The following draft reports were received–a Los Angeles Council case study report, a Minnesota case study report, three reports based on the pre-managed care surveys in New York State, two reports based on pre-managed care surveys in Kentucky, and one report on the Vermont Health Access Program pharmacy benefit program. 4) Two reports were finalized: The Medicaid Demonstration Project in Los Angeles County, 1995-2000: Progress, But Room For Improvement and Health Care Use, Access, Use, and Satisfaction Among Disabled Working-Age Adults in New York under FFS Medicaid. 5) Due to unanticipated delays and/or cancellation of mandatory Medicaid managed care programs in Kentucky and New York, it is unlikely that the post-managed care surveys will be fielded in these States. Work has begun on a contract modification that would redirect project resources to other tasks.

95-028 Evaluation of the Diamond State Health Plan

Project Officer: Penelope Pine
Period: September 1994–January 2003
Awardee: Research Triangle Institute, (DC)
Funding: $498,035

Description: The original purpose of the contract was to evaluate the Delaware Health Care Partnership for Children, specifically the effectiveness of the demonstration in reaching its goal of improving access to and the quality of health care services delivered to Medicaid-eligible children in a cost-effective way. The State believed that by enrolling children into a managed-care system operated by the Nemours Foundation, they would reap the benefits of a higher level of coordinated care, while the State, and in turn the Federal Government, would benefit from lower Medicaid costs. The contract was modified to focus more generally on the impacts of the Diamond State Health Plan on children, including children with special health care needs (the original evaluation had been limited to the Nemours Children's Clinics). The goal of the evaluation was broadened to assess whether this section 1115 demonstration's objective of increased access to high-quality, cost-effective care for Medicaid children is being met.

Status: The following topics have been analyzed:

- The effect of managed care implementation in Delaware on the number and population of pediatric Medicaid beneficiaries receiving treatment for asthma
- Children with special health care needs and the relationship of the education system and managed care.

95-029 Minnesota Prepaid Medical Assistance Project Assistance Plus (PMAP+)

Project Officer: Joseph Millstone
Period: July 1995–June 2005
Awardee: Minnesota, Department of Human Services
Funding: $0

Description: The Minnesota Prepaid Medical Assistance Project Plus (PMAP+) amended the original Minnesota Medicaid Demonstration by expanding the project in both size and scope. The PMAP demonstration enrolled all Aid to Families with Dependent Children eligibles, needy children, and pregnant women in eight Minnesota counties into prepaid managed-care organizations. PMAP+ originally expanded prepaid managed care to nine additional counties and is expected to eventually be a statewide program. In addition, Medicaid eligibility was expanded on a statewide basis to include children and pregnant women up to 275 percent of the Federal poverty level who were previously covered under the State's MinnesotaCare program. Subsequent changes included expanding eligibility to include parents and caretaker relatives of children enrolled in the demonstration. The approval of Phase 2 in August 2000 allowed several changes which involved increasing flexibility for the State, particularly related to capitation payment. In July 2001, an amendment was approved to allow implementation of county-based purchasing by the Sour County Health Alliance encompassing nine rural Minnesota counties.

Status: Currently, there are approximately 305,000 enrollees in PMAP+ managed care organizations. In addition, the State's eligibility expansion has made approximately 108,000 MinnesotaCare children, caretaker adults and pregnant women Medicaid-eligible. Some parents and caretaker adults are now covered under the State's Children's Health Insurance Program (SCHIP) and receive their care through the MinnesotaCare delivery system. Minnesota now operates Medicaid managed care in 69 of its 87 counties. Minnesota was granted an extension of its demonstration from June 2002 to June 2005.

96-008 Oklahoma SoonerCare Demonstration

Project Officer: Donna Schmidt
Period: October 1995–December 2003
Awardee: Oklahoma, Health Care Authority
Funding: $0

Description: SoonerCare fosters the creation of a managed-care infrastructure in urban and rural areas, thus increasing access to primary care for beneficiaries throughout the State and allowing for greater financial predictability of the State Medicaid program. SoonerCare uses fully capitated delivery systems in urban areas and requires urban plans to be "rural partners" by expanding their provider networks into adjacent rural areas. The urban health plan/rural partner program was implemented July 1996 for Temporary Aid to Needy Families (TANF) and TANF-related beneficiaries. In rural areas without managed-care organizations, a partially capitated primary care physician/case management (PCP/CM) model is used. The PCP/CM program was piloted in a tri-county area beginning April 1996 and was implemented statewide in October 1996. The program currently serves 319,365 beneficiaries. This includes TANF and TANF-related populations, as well as beneficiaries who are aged, blind, and disabled (ABD). The State implemented the program for the entire noninstitutionalized ABD population in July 1997.

Status: The project has been extended through 2003.

99-071 Evaluation of the MassHealth Quality Improvement Plan and Insurance Reimbursement Program

Project Officer: Carol Magee
Period: September 1999–March 2002
Awardee: Health Economics Research
Funding: $682,313

Description: This project studies two features of the Massachusetts Medicaid plan known as "MassHealth": First, the Insurance Reimbursement Program. Massachusetts is among the first States to attempt to assure employer-sponsored insurance for low-income workers. The project evaluates the process established by this Massachusetts Medicaid demonstration of increasing enrollment of low-income workers earning less than 200 percent of the Federal poverty level in employer-sponsored health insurance. It provides data on the success of this program, e.g., number of employees enrolled, number of children and adults receiving insurance, number of small employers adding insurance coverage for low-income employees. Second, the Quality Improvement Plan. MassHealth has attracted interest because of its innovative method of including quality assurance with improvement in contracting with both managed care organizations (MCOs) and primary care clinicians. The case study portion of the project describes the operation and assesses the effectiveness of the quality improvement plan for both primary care clinicians and the MCOs.

Status: Additional data collection, particularly regarding small business participation, will soon begin. For Part II, which describes the Quality Improvement Plan, all site visits have been completed, and the first annual report is under draft. The final descriptive presentation is being planned.

95-024 MassHealth: Massachusetts Health Reform Demonstration

Project Officer: Sharon Donovan
Period: April 1995–June 2002
Awardee: Commonwealth of Massachusetts, Division of Medical Assistance
Funding: $0

Description: This project is the Massachusetts Medicaid demonstration, entitled "MassHealth." A waiver was approved in April 1995. MassHealth makes comprehensive health care coverage available to approximately 259,000 uninsured poor and low-income individuals and families at risk of losing private health insurance. The Commonwealth estimates that a majority of the uninsured in families with income under 200 percent of the Federal poverty level will become insured through MassHealth. The other targeted populations include low-income short-term unemployed, working disabled adults and disabled children, populations limited by insurance administration barriers (i.e., pre-existing condition exclusions and waiting periods), and small businesses and nongroup members seeking purchasing leverage. MassHealth represents a set of strategies to improve access to health insurance and to stimulate the offering of affordable private insurance coverage. The program

builds on the Commonwealth's existing managed-care program, which is made up of health maintenance organizations and a primary care clinician program, and existing State-only programs for the disabled and short-term unemployed. The demonstration is composed of the six strategies that streamline eligibility for the current Medicaid program, provide health insurance for non-Medicaid-eligible disabled and the unemployed, advance existing Medicaid managed-care programs, and make employer and employee subsidies available for health insurance coverage for the working poor.

Status: The State began providing services under the demonstration in July 1997 and total enrollment as of June 2001 was approximately 816,483, which included traditional and expansion eligibles. Service delivery continues to be through the primary care clinician program and health maintenance organization (HMO) options that were part of the prior section 1915(b) demonstration, with the addition of HMOs developed by each of the Boston Public Health Commission and the Cambridge Public Health Commission. During calendar year 1999 the State began implementation of employer and employee subsidies for private health insurance. In 2001, the State received approval to expand coverage to individuals with HIV below 200 percent of the Federal Poverty Level. In December 2001, the State received approval for a three-year extension of the demonstration. The project is approved through June 2003.

00-132 Evaluation of the BadgerCare Medicaid Demonstration

Project Officer: Paul Boben
Period: September 2000–March 2003
Awardee: Research Triangle Institute, (NC)
Funding: $1,315,271

Description: The purpose of this project is to conduct an evaluation of BadgerCare, Wisconsin's Section 1115 Medicaid Demonstration and S-CHIP program. The goals of BadgerCare are to increase access to health insurance for low-income families, and to support families making the transition from welfare to work. The program uses State funds and Federal matching funds from the Title XIX (Medicaid) and Title XXI (SCHIP) programs to extend public health insurance coverage to families with incomes up to 200 percent FPL. Section 1115 waivers were awarded to allow the State to use the Title XIX and XXI funds in this manner. The evaluation will determine whether BadgerCare has succeeded in meeting its stated objectives, and whether Wisconsin's experience with BadgerCare can be of help to other States considering similar reforms.

Status: The Final Design Report for the study was submitted to CMS in March 2001. Work on the case study component began in March and continued through October, and a draft Case Study Report is expected in early 2002. Design work on survey instruments took place in Spring 2001, in anticipation of fielding the surveys in early 2002.

02-073 Evaluation of Medicaid Family Planning Demonstrations

Project Officer: Julie Jones
Period: September 2002–September 2003
Awardee: C.N.A. Corporation
Funding: $245,931

Description: The purpose of this project is to evaluate the impact and effectiveness of Medicaid section 1115 family planning demonstrations. While each State has a slightly different program, all of the demonstrations expand Medicaid eligibility for family planning services to women and, in some States, men also. Under Medicaid, State eligibility includes pregnant women and infants under 133 percent of poverty, and may provide services, including family planning services, related to pregnancy and other conditions that may complicate pregnancy. States are also required to cover these services for two months post-partum.

Cash and Counseling Demonstrations

The purpose of these demonstrations is to provide greater autonomy to consumers of long term care services by empowering them to purchase the

assistance they require to perform activities of daily living. They are Section 1115 waiver projects awarded to the States of Arkansas, Florida, New Jersey, and New York. Persons chosen to participate in these demonstrations are assigned to either a treatment or a control group. Beneficiaries selected for the treatment group receive cash allowances, which they can use to select and purchase the personal assistance services (PAS) that meet 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 receive PAS services from traditional Medicaid providers, with the State making all vendor payments. 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, the National Program Office at the University of Maryland's Center on Aging and the National Council on Aging.

99-011 Arkansas Cash and Counseling Demonstration: "Independent Choices Program"

Project Officer: Elizabeth Mack
Period: October 1998–October 2003
Awardee: Arkansas, Department of Human Services
Funding: $0

Status: The State has enrolled approximately 1,825 participants and assigned them to treatment or control groups. Efforts to increase enrollment continue.

99-014 New York Cash and Counseling Demonstration: "Personal Preference Program"

Project Officer: Sandy Khoury
Period: October 1998–October 2003
Awardee: New York, Department of Health, (Albany)
Funding: $0

Status: The Robert Wood Johnson Foundation and the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, have terminated their funding of this proposed New York project.

99-013 New Jersey Cash and Counseling Demonstration

Project Officer: Melissa Harris
Period: October 1998–October 2003
Awardee: New Jersey, Department of Human Services
Funding: $0

Status: New Jersey was given authorization to begin randomizing enrollees in November 1999. Since then, 515 individuals have been randomized into the control group and 506 have been randomized into the treatment group.

99-012 Cash and Counseling Demonstration: Florida's "Consumer-Directed Care Program"

Project Officer: Andrew Mack
Period: October 1998–October 2003
Awardee: Florida, Agency for Health Care Administration, (Mahan Dr)
Funding: $0

Status: An evaluation contract has been awarded to Mathematica Policy Research, Inc. It will assess differential outcomes with respect to cost, quality, and client satisfaction between traditional PAS services and alternative choice modalities.

01-280 Environmental Factors that Increase the Risk of Asthma in Medicaid Recipients

Project Officer: David Greenberg
Period: September 2001–June 2003
Awardee: National Aeronautics and Space Administration, Goddard Space Flight Center
Funding: $270,000

Description: This project involves the analysis of Maryland Medicaid data for children with asthma. It will investigate how environmental factors can help predict trends in medical service utilization by Medicaid-eligible children with asthma. Data on asthma-related inpatient medical care, outpatient medical services, and prescription medication use for children in Baltimore City will be used. Seasonal and geographic patterns in utilization will be identified. It will try to identify significant trigger variables and interpret relationships between environmental conditions and Medicaid utilization patterns.

Status: The project is newly underway.

94-105 Extension of Medicaid Benefits for Post-Partum Women

Project Officer: Pamela Forton
Period: January 1994–January 2002
Awardee: South Carolina, Department of Health and Human Services
Funding: $0

Description: This section 1115 Medicaid demonstration provides family planning services to women with income at or below 185 percent of the Federal poverty level (FPL), and, additionally, provides primary care services. The primary goals of the demonstration are to reduce the incidence of unintended and unplanned pregnancies, increase intra-partum periods to 24 months, and decrease Medicaid expenditures resulting from unintended and unplanned pregnancies. With the addition of promoting access to primary care services, additional goals include the promotion and assurance of a medical home, continuity of care, and access to necessary services for demonstration participants. This demonstration provides services to approximately 77,000 women.

Status: The demonstration was awarded in December 1993 and was implemented July 1994. The amendment to extend demonstration eligibility to all women with incomes up to 185 percent of the FPL was awarded January 1997 and the amendment was implemented June 1997. The latest demonstration period expired December 2001, and the State is currently operating under an extension for the period through January 2002.

99-100 Analysis of State Medicaid Program Experience with Assertive Community Treatment (ACT) Programs for Persons with Mental Illness

Project Officer: Peggy Clark
Period: September 1999–September 2002
Awardee: Substance Abuse and Mental Health Services Administration, CMHS, DKDSC
Funding: $300,000

Description: This project evaluates the State experience in supporting evidence-based Assertive Community Treatment (ACT) programs for persons with serious and persistent mental illness. The evaluation examines the factors that contribute to the successful implementation of these programs at the State level–how States are using Medicaid and other resources to support these programs and how programs are designed to meet the needs of the particular population to be served. The study includes a focus on issues in ACT implementation and evaluation in rural and other settings, and how programs are being tailored to address diversity and cultural competence issues. The agreement supports a 2-year collaboration on an analysis of ACT programs for persons with mental illness and the use of Medicaid in financing such programs in eight States. To provide an information base for technical assistance to States about the implementation and financing of ACT programs, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) want to examine factors that contribute to the successful implementation of these programs in States and to provide a Budget Simulation Model and a Resource Guide for State officials.

Status: This agreement has been modified as of July 2001 with CMS adding $150,000 and extending the time period to September 30, 2002. The modification renumber the agreement from HCFA-IA-99-110 to HCFA-IA-01-110.

96-004 Demonstration Project for Family Planning and Preventive Reproductive Services, State of Maryland

Project Officer: Linda Welle
Period: October 1994–January 2002
Awardee: Maryland, Department of Health and Mental Hygiene
Funding: $0

Description: Under this demonstration project, the State of Maryland extends Medicaid eligibility for family planning services to women who are Medicaid-eligible because of their pregnancy. These women remain Medicaid-eligible 60-days postpartum (i.e., for those women who fall in the Pregnant Women and Children eligibility category). The State intends to demonstrate that covering family planning and preventive reproductive services for these women will reduce Medicaid payments by reducing their number of unintended births and by improving their health status through preventive care. The demonstration waivers run through January 30, 2000, with the last year of the project devoted to evaluation activities. An amendment to incorporate this demonstration project into the State's comprehensive 1115 demonstration is under review for approval.

Status: The State and CMS are working to incorporate this project into the existing health care reform demonstration. This project is being held open until this incorporation is complete.

00-125 Moving Towards Elimination of Lead Poisoning in High Risk Children

Project Officer: Cheryl Austein-Casnoff
Period: September 2000–September 2002
Awardee: Abt Associates
Funding: $749,952

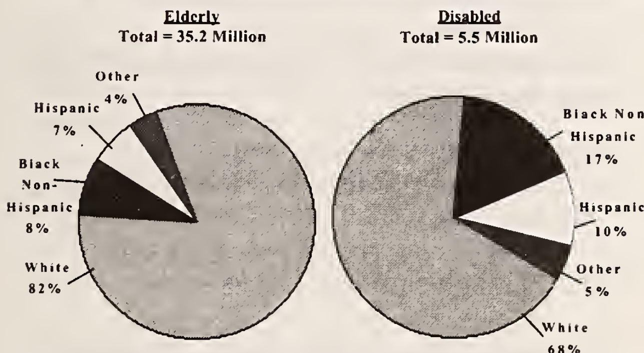
Description: The purpose of this project is to develop a strategy to eliminate exposure to lead hazards among high risk children by: 1) developing risk appropriate screening criteria for all children, with special emphasis on improved targeted screening of low-income children; and 2) developing an implementation plan for the elimination of lead hazards facing children, bringing together the expertise and authorities of Federal Government and appropriate State and local agencies.

Status: The project workplan has been developed. The staff are reviewing literature, searching relevant databases, and looking at potential model communities.

Theme 6: Meeting the Needs of Vulnerable Populations

A special focus of this research area is the demonstration of coordinated care models that integrate the range of services available to persons who are dually eligible for Medicare and Medicaid. Development of a risk adjustment system to support capitated payment for dual eligibles is a key element of this activity. We are implementing and evaluating demonstrations for the dually eligible population and exploring ways to improve coordination between the Medicare and Medicaid programs. Our research and demonstration projects are investigating disparities in clinical treatment for chronic disease, by gender and race/ethnicity to achieve improved health outcomes for vulnerable populations by targeting policies, programmatic changes, education, and outreach activities.

Minority Beneficiaries are Disproportionately Represented Among the Disabled



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care Files.

95-089 State of Minnesota Senior Health Options (MSHO) Project

Project Officer: Susan Radke
Period: April 1995–December 2004
Awardee: Minnesota, Department of Human Services
Funding: $0

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 dual eligibles. Under this demonstration, the State is being treated as a health plan that contracts with CMS to provide services, and provides those services through subcontracts with three health care plans. The State targets the elderly dually-entitled and Medicaid eligible only population that reside in the ten county St Paul/Minneapolis metropolitan area. Elderly Medicaid eligibles required to enroll in the State's current section 1115 Prepaid Medical Assistance Program (PMAP) demonstration have the option to enroll in the Minnesota Senior Health Options (MSHO) Project. The MSHO project provides additional long-term care and Medicare benefits to basic PMAP benefits. The State is continuing its current administration of the Medicaid-managed care program while incorporating some Medicare requirements that apply directly to the health plans with which the State would subcontract for MSHO.

Status: CMS approved the State's request 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 dual eligible beneficiaries and Medicaid eligible only beneficiaries. Administration of this program is similar to MSHO and the State currently contracts with one health plan to provide services to the disabled population. The MSHO extension and MnDHO expansion are approved through the period of October 2001 through December 2004.

97-218 Multi-State Evaluation of Dual Eligibles Demonstrations

Project Officer: Noemi Rudolph
Period: September 1997–September 2005
Awardee: University of Minnesota, (Wash Ave)
Funding: $5,623,414

Description: This evaluation is designed to assess the impact of dual eligible demonstrations in the States of

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Minnesota, Wisconsin and New York. Analyses will be conducted for each State and across States. The quasi-experimental design will utilize surveys, case studies, and Medicare and Medicaid data for analysis. Major issues to be examined include the use of a capitated payment strategy to expand services while reducing/controlling costs, the use of case management techniques and utilization management to coordinate care and improve outcomes, and the goal of responding to consumer preferences while encouraging the use of noninstitutional care. A universal theme to be developed is the difference between managing and integration.

Status: Surveys of beneficiaries and their families have been completed in Minnesota and Wisconsin. The surveys gathered information on several areas including satisfaction, the use of formal and informal care, and informal caregiver burden. Three Annual Reports and two case study reports have been submitted to CMS. The New York demonstration received its waivers in September 1999 and is still working through pre-implementation issues prior to the start of enrollment. Due to the delay in implementing the dual eligible demonstrations within the scope of this project, the period of performance was extended at no cost to the government from September 2002 through September 2005.

98-202 Multi-State Dual Eligible Data Base and Analysis Development

Project Officer: William Clark
Period: September 1997–September 2002
Awardee: Mathematica Policy Research, (Princeton)
Funding: $2,135,418

Description: This project will use available Medicare/Medicaid-linked statewide data in 10-12 States to develop a uniform database that can be used by States and the Federal Government to improve the efficiency and effectiveness of the acute- and long-term-care services to persons eligible for both Medicare and Medicaid (dual eligible). It will also conduct analyses derived from these data to strengthen the ability to develop risk-adjusted payment methods and deepen the understanding of Medicare-Medicaid program interactions as they relate to access, costs and quality of service. Finally, it will recommend longer-range options that will improve the usefulness of the database for operational and policy purposes.

Status: The project is constructing a multi-State dual eligible database and using these data for analyses. Two years of the database have been constructed. However, the third year of Medicaid data has been unavailable for inclusion in the database due to problems external to this contract. Preliminary descriptive reports are being prepared with the 2 years of data, and research studies continue.

99-115 Continuing Care Network Demonstration, Technical Assistance and Third Party Assessments

Project Officer: Noemi Rudolph
Period: September 1999–June 2002
Awardee: Community Coalition for Long Term Care
Funding: $556,757

Description: This is part of a multi-year technical assistance and third party assessment for the Continuing Care Network (CCN) demonstration project in Monroe County. Specific objectives include: 1) analyzing and comparing Medicare+Choice capitation methodology with the CCN demonstration risk-adjusted payment model; 2) collecting assessment data; designing and empirically testing a Medicare and Medicaid risk/savings sharing model, and 4) examining CCN strategies for outreach/education, marketing, and enrollment especially as it pertains to the frail and dual eligibles.

Status: Deliverables submitted by the project include a databook and three reports: the Monroe County Medicare-Medicaid Integrated Database Databook, Determinants of Medicare and Medicaid Spending and the Implications for Risk Adjustment: Initial Report, and Pre-Demonstration Focus Groups: The Challenges of Attracting, Enrolling and Retaining Impaired and Dually Eligible Seniors in a Comprehensive Managed Care Program (Final Report), and Determinants of Medicare and Medicaid Spending and the Implications for Risk Adjustment (Final Report). Demonstration implementation issues have impacted the progress of

this project. Due to budget limitations, this technical assistance project will phase out in the summer of 2002.

99-114 Continuing Care Network Demonstration

Project Officer: Noemi Rudolph
Period: September 1999–September 2005
Awardee: New York, Department of Health, Bureau of Continuing Care Initiatives
Funding: $0

Description: This is a 5-year demonstration designed to test the efficiency and the effectiveness of financing and delivery systems that integrate primary, acute, and long-term care services under combined Medicare and Medicaid capitation payments based on functional status. The Continuing Care Networks (CCNs) will enroll, over a five-year period, at least 10,000 Medicare-only and dually eligible beneficiaries who are 65 or older in Monroe County, New York. This population will include those residing in nursing facilities, the nursing-home certifiable living in the community, and the unimpaired. A limited chronic care benefit will be available to all who join the CCN as community-based unimpaired participants on enrollment. This is a voluntary program for both Medicare and dually eligible beneficiaries.
Status: The demonstration has experienced several implementation issues and therefore has not begun enrollment to date.

99-041 Case Studies of Managed Care Arrangements for Dual Eligible Beneficiaries

Project Officer: William Clark
Period: August 1999–February 2002
Awardee: Health Economics Research
Funding: $367,135

Description: The purpose of this project is to obtain greater knowledge of the dynamics of Medicare and Medicaid coordination of eligibility, benefits, and services at the health plan level. It will provide preliminary identification of issues that CMS, States, health plan contractors, and beneficiaries should prioritize and address. It will identify exemplary and routine approaches implemented by health plans for further consideration and potential adoption by others. Four market areas were selected for the studies: Portland, Oregon; Philadelphia, Pennsylvania; Miami, Florida; and Los Angeles, California. Beneficiary focus groups also will be convened to obtain beneficiary perceptions and experiences in using Medicare and Medicaid benefits in their managed care plans.

Status: Focus group activities in 2001 are completed.

99-056 Development and Validation of a Performance Measure Set for the Evaluation of Medicaid Services Rendered to People with Developmental Disabilities

Project Officer: Elizabeth Couchoud
Period: September 1999–September 2002
Awardee: Research Triangle Institute, (NC)
Funding: $793,190

Description: This project is to select and validate a performance measure set that will be used to evaluate the quality and appropriateness of Medicaid services rendered to people with developmental disabilities. It is expected that the measure set developed will be useful within CMS' regulatory quality monitoring programs and to inform quality improvement activities.
The measure set will also be available to provide information to consumers, to provide information on system-wide strengths and weaknesses, and to provide information to payers of health care, including CMS, States, and private payment sources for use in evaluating the quality and value of services. This project will first recommend and then alpha test a performance measure set to determine its utility and feasibility for use in intermediate care facilities/mentally retarded (ICFs/MR).

Status: The selection of indicators and alpha test took place in calendar year 2001.

00-131 Disabled and Special Needs Populations: Examining Enrollment, Utilization and Expenditures

Project Officer:	James Hawthorne
Period:	September 2000–September 2003
Awardee:	Mathematica Policy Research, (Princeton)
Funding:	$1,024,697

Description: The purpose of this project is to create a linked database that combines information from the Social Security Administration's (SSA) administrative data with CMS Medicaid data. It complements and builds upon activities related to these special needs populations by other components in the Department of Health and Human Services. Specifically, the project will 1) link CMS Medicaid and SSA disability data; 2) provide baseline data on enrollment, utilization, and payments for disabled and special needs enrollees in Medicaid; and 3) conduct research on policy issues related to these groups of enrollees. Of special interest will be the information on "reason for disability." At completion, the project will deliver a database that provides the opportunity for special studies and analyses designed to answer particular questions about the disabled and special needs populations, e.g., their health care needs and utilization and the costs of providing their health care. It will also provide special studies on questions of particular interest.

Status: The project has identified selected study objectives and has been negotiating with SSA to obtain data from their systems.

01-215 Assessment of State Database Capacity and Development of Prototype Performance Monitoring System

Project Officer:	Joe Razes
Period:	September 2001–August 2002
Awardee:	Oregon Health and Science University
Funding:	$296,037

Description: The goal of this project is to lay the groundwork for the development of a national database that will integrate relevant Medicaid buy-in administrative data sets for future analysis. This project collects, analyzes, and interprets data regarding States' Medicaid health systems development activities for individuals with disabilities and will develop a performance monitoring tool. This tool would be used by States in evaluating the success of their buy-in programs. Recent legislation has offered States unprecedented opportunities to use Medicaid as a vehicle for supporting the competitive employment of people with disabilities. This project also will support the identification and reporting of performance measures and benchmarks for use in evaluating the effectiveness of Medicaid buy-in programs.

Status: This project is in the startup phase.

01-262 Demonstration Project to Establish an Independent Investigative Unit for Deaths and Abuse of the Disabled

Project Officer:	Mary Clarkson
Period:	September 2001–September 2002
Awardee:	Equip for Equality
Funding:	$150,000

Description: This project established an in-house investigative unit to review deaths and other serious incidents of abuse or neglect of persons with disabilities. It will develop criteria for selecting cases to be directly investigated, and examine existing investigations systems to determine whether incidents of neglect are reviewed across all settings. A voluntary pro bono Medical Review Board will review cases flagged and provide advice on cases deserving investigation. An Advisory Committee with representatives from major Illinois State governmental units responsible for investigations will participate in developing criteria to be used in selecting incidents to investigate. It will also insure that emphasis is placed on areas that are not duplicative of current Federal and State efforts to insure recipient safety. Finally, the project will engage in public awareness activities.

Status: The project is in its early stages.

01-142 Medicare Behavioral Health Cost and Use Study

Project Officer: James Hawthorne
Period: July 2001–July 2002
Awardee: Abt Associates
Funding: $244,659

Description: This project is developing a systematic process for monitoring Medicare expenditures for beneficiaries with behavioral health disorders. Information from the Medicare Enrollment Data Base (EDB) and from Medicare claims files will be used to identify and categorize beneficiaries in terms of relevant indicators of behavioral health problems. Utilization and expenditures for these beneficiaries will then be compared to those of other Medicare beneficiaries.

Status: At present, the project focuses only on Medicare expenditures. Subsequent projects however, will include an examination of Medicaid expenditures for dually eligible beneficiaries and the relationship between both Medicare and Medicaid expenditures and disability status under the Social Security Disability Insurance program.

02-062 Implementation of the READII Survey

Project Officer: Susan Arday
Period: September 2002–September 2003
Awardee: Abt Associates
Funding: $350,000

Description: CMS and the Centers for Disease Control and Prevention (CDC) are working with five demonstration sites to improve influenza and pneumococcal vaccination rates in African-American and/or Hispanic communities. This contract will implement the READII Survey to a sample of Medicare beneficiaries randomly selected from each of the five demonstration sites. Information will be collected via a telephone survey to evaluate the impact of the Racial and Ethnic Adult Disparities in Immunization Initiative. The demonstration sites use a coalition of public health professionals and medical providers to develop a community-based plan that will identify African-American and Hispanic individuals, who are 65 years of age and older in need of influenza and pneumococcal vaccinations, and offer these immunization services to them.

Status: The five demonstration sites are: Chicago, Illinois; Bexar County, Texas; Milwaukee, Wisconsin; Monroe County, New York; and selected counties in rural Mississippi.

00-174 Diabetes Care Across the Life Span for Medicaid Beneficiaries: Gender and Racial Differences

Project Officer: Rosemarie Hakim
Period: August 2001–January 2003
Awardee: Health Economics Research
Funding: $214,592

Description: This project complements the research CMS is conducting on diabetes care in the Medicare population. It will provide information on diabetes in children, youth and/or adults who are Medicaid beneficiaries. It supports CMS to better understand the magnitude and patterns of utilization of health care services for beneficiaries with diabetes, and specifically the racial/ethnic composition of beneficiaries so that culturally relevant interventions can be developed to improve access and health outcomes. Findings from this analytic study will assist in setting new directions for future studies and program activities related to diabetes education, prevention and treatment to improve access and health outcomes for our beneficiaries in the Medicaid program.

Status: This project is in the startup phase.

01-167 American Indian/Alaska Native Eligibility and Enrollment in Medicaid, the State Children's Health Insurance, and Medicare

Project Officer: Linda Greenberg
Period: September 2001–September 2003
Awardee: Barents Group
Funding: $898,353

Description: In 1998, national goals were established to eliminate health disparities by the year 2010 in six areas: infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV/AIDS rates; and child and adult immunization levels. This project is one part of a larger effort to eliminate health disparities. It will assess eligibility and enrollment of American Indians/Alaska Natives (AI/AN) in Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare and determine the proportion of the eligible AI/AN population enrolled in Medicaid, SCHIP, and Medicare. Analyses will be conducted using the latest available eligibility and enrollment data from State Medicaid and SCHIP programs, and the Medicare program. Data on the AI/AN population will also be identified using U.S. Census data on a State- and county-level basis, and other possible databases. One of the aims of this study is to identify geographic areas of low enrollment in Medicaid, SCHIP, and Medicare so that CMS may more effectively engage in culturally-specific education and outreach efforts.

Status: In progress.

01-151 Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project

Project Officer:	Diane Merriman
Period:	September 2001–November 2002
Awardee:	Brandeis University, Heller Graduate School, Institute for Health Policy
Funding:	$835,533

Description: The purpose of this project is to identify promising models of cancer prevention, detection and comprehensive care that promote health and appropriate utilization of Medicare covered services, in order to help eliminate health care disparities among Medicare beneficiaries. This project will evaluate best practices in the private sector, community programs, and academic research. Emphasis is being placed on interventions that promote primary prevention, such as programs that influence behavioral risk factors; secondary prevention interventions that promote the use of clinical preventive and screening services; and interventions that may include treatment. CMS plans at least 9 demonstration projects in specified target groups for the purpose of developing models and evaluating methods that: 1) improve the quality of items and services; 2) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns; 3) eliminate disparities in the rate of preventive cancer screening measures; and 4) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

Status: The "Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project" is a multi-year project that has two phases. The first phase involves producing an evidence report that will synthesize evidence/best practices on intervention models that promote primary and secondary prevention interventions among the targeted ethnic and racial minority populations. The focus of these reports will be the interventions; i.e., what steps, conditions or actions are necessary for success, and their relevance to the Medicare program. The second phase involves the design and implementation of behavioral risk factor reduction and health promotion demonstrations.

01-263 A Plan to Address Health Disparities in the African American Communities

Project Officer:	Richard Bragg
Period:	June 2001–January 2002
Awardee:	Eleanor Walker, Ph.D.
Funding:	$25,000

Description: This project will develop recommendations and strategies for shaping a future research agenda regarding health disparities in the African American population.

Status: The project is complete.

01-265 American Indian/Alaskan Native Consultation on Health Disparities Research

Project Officer: Linda Greenberg
Period: July 2001–January 2002
Awardee: Debra Buckwald, MD
Funding: $25,000

Description: This project will assist in the development of a strategic research plan to address health disparities in these populations. It will develop recommendations and strategies for shaping a future research agenda regarding health disparities.

Status: The project is complete.

01-288 Minority Health: Asian American Research

Project Officer: Richard Bragg
Period: June 2001–January 2002
Awardee: Elena Yu
Funding: $25,000

Description: This project developed a plan to address health disparities in the Asian American community.

Status: The project is complete.

00-092 Examining Gender and Racial Disparities Among Medicare Beneficiaries with Chronic Diseases

Project Officer: Marsha Davenport
Period: September 2000–March 2002
Awardee: Health Economics Research
Funding: $177,442

Description: This project is an analytic study using the Medicare administrative claims files to expand CMS' knowledge base in the area of women's health and chronic diseases. Findings from this project will assist CMS in targeting policies, programmatic changes, education, outreach, and research and demonstration projects to achieve improved health outcomes for female Medicare beneficiaries. Diseases such as arthritis, asthma, chronic obstructive pulmonary disease (COPD) and other respiratory conditions, cancers, diabetes, heart disease, hypertension, osteoporosis, and stroke comprise the major categories of chronic conditions affecting persons age 65 and older. For women, cardiovascular disease is responsible for more deaths than almost all of the leading causes of death, including cancer. Recent studies have identified disparities in treatment for heart disease both by gender and race/ethnicity. There are a growing number of racial and/ethnic groups in this country who appear to be disproportionately sharing the burden of these chronic diseases.

Status: Analysis on stroke (hemorrhagic; ischemic; and transischemic attacks) and co-morbid diseases is in progress.

00-069 Health Disparities: Longitudinal Study of Ischemic Heart Disease Among Aged Medicare Beneficiaries

Project Officer: Linda Greenberg
Period: September 2000–September 2002
Awardee: Health Economics Research
Funding: $282,157

Description: The purpose of this project is to assess the use of Medicare covered services among Medicare beneficiaries with ischemic heart disease (IHD) based on sociodemographic characteristics (e.g., race/ethnicity, sex, age, socioeconomic status). This is being done using a longitudinal database comprised of 1997-1999 data that links Medicare enrollment and claims data with small-area geographic data on income (e.g., U.S. Census data or other private data sources). The advantage of a longitudinal database is that it provides data at multiple time points during a person's life. Information is being used to compare the incidence of disease and the outcomes of diagnostic and surgical procedures for IHD across racial/ethnic groups, socioeconomic status, and geographic areas. The unique aspect of this contract is that it examines cardiovascular care among Whites, Blacks, Hispanics, Asians, and American Indians/Alaskan Natives. This project addresses a HHS initiative to eliminate health disparities, which is one of the goals of Healthy People 2010.

Status: A Final Design and Analytic Report was completed in June 2001. Using the longitudinal Part A database, a draft report provides preliminary results including data on admission rates, mortality rates, readmission rates, and inpatient procedure rates for IHD patients. It also characterizes the types of hospitals IHD patients go to when first admitted for IHD. This report is the first in a series of reports.

00-093 Racial Disparities in Health Services Among Medicaid Pregnant Women, (Multi-State) Analysis

Project Officer: M. Beth Benedict
Period: September 2000–September 2002
Awardee: Research Triangle Institute, (NC)
Funding: $430,779

Description: This is a study of associations between pregnancy-related care and outcomes, and the ethnic and racial characteristics of women who had a Medicaid-covered delivery during calendar year 1995. The study examines the use of Medicaid expenditures from health services from the initial prenatal care visit through the delivery and into the first three postnatal months. Specific prenatal care markers being considered include delayed prenatal care, no prenatal care, and an insufficient total number of prenatal care visits for a full-term, normal pregnancy. For each of the health care utilization analyses, expenditure is being analyzed.

Status: During year 1 of the project, analysis files were constructed and preliminary analyses completed on population use and expenditures in prenatal care for three of the four States. In year 2, the project is continuing the analyses.

00-121 Health Status and Quality of Life for Women with Diabetes: Data from the Medicare Current Beneficiary Survey

Project Officer: Marsha Davenport
Period: September 2000–September 2002
Awardee: CHD Research Associates
Funding: $92,490

Description: This project develops a database, creates analytic files, and provides programming and analytic support for studies on beneficiaries with diabetes from the Medicare Current Beneficiary Survey (MCBS). These studies will focus on gender and racial/ethnic differences for respondents in the MCBS who reported having had a diagnosis of diabetes. Through creating a database and analytic files, studies on Medicare beneficiaries with diabetes can be conducted using several years of data from the MCBS. Important issues related to health, health status, co-morbid conditions, functional status, disability, and quality of life, as well as costs and utilization of health care services, can be examined.

Status: Preliminary descriptive data analyses, both unweighted and weighted, were completed for the demographic characteristics of beneficiaries with diabetes from MCBS. Additional analyses are planned to compare the persons with diabetes to beneficiaries without diabetes on such variables as risk factors, activities of daily living and instrumental activities of daily living, co-morbid diseases, medications, and use of preventive services. Future analyses will also include data from the Medicare claims files to study the use of appropriate services for the management of diabetes.

02-054 Health Disparities: Measuring Health Care Use and Access for Racial/Ethnic Populations

Project Officer: Linda Greenberg
Period: September 2002–September 2003
Awardee: Research Triangle Institute, (DC)
Funding: $284,870

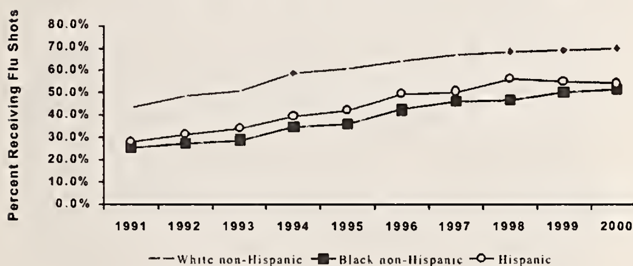
Description: The purpose of this project is to analyze health care access trends among minority beneficiaries and determine whether and the extent to which health care disparities exist among minority populations including those who have not previously been studied using Medicare data. In addition, this project will focus on examining the accuracy and completeness of race/ethnicity data in the Medicare enrollment database.

Status: This project is in the startup phase.

Theme 7: Outcomes, Quality and Performance

The CMS research, demonstration, and evaluation agenda involves the development and testing of improved information resources to enable consumers to choose among health plans and providers based on their relative value and quality. One part of this agenda seeks to better understand how choices are made. The aim is to develop better tools for measuring health care outcomes and quality, as well as the performance of health plans and providers. Projects in this area include: development and assessment of performance measures, developing and testing approaches for selective contracting with providers (institutions and Medicare contracting health plans) based on quality, implementing and evaluating the Medicare lifestyle modification program demonstration, and developing new quality measures, especially for rehabilitation hospitals.

Utilization of flu shots was higher for white non-Hispanic beneficiaries than other racial groups, but rates for all groups increased over the decade.



Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 1991-2000 Access to Care Files.

00-122 Development and Production of the Medicare Quality Monitoring System

Project Officer: Benedicta Abel-Steinberg
Period: September 2000–September 2002
Awardee: Health Economics Research
Funding: $1,173,065

Description: The CMS Medicare Quality Monitoring System (MQMS) tracks various aspects of the health status and health care of the Medicare beneficiaries using a combination of survey and administrative data. The primary goal of the MQMS is to collect, analyze, and interpret national and/or State-specific health data (both surveys and administrative data) on service utilization, health status and outcomes on morbidity and mortality relevant to CMS's Health Care Quality Improvement Project (HCQIP). The secondary goal is to disseminate the health and quality of care data/information to support quality of care improvement efforts and to promote HCQIP-related studies. Specifically, this effort produces two sets of data and information. One exhibits the trends, patterns and variations of service utilization and health status of Medicare beneficiaries, while the other exhibits the trends, patterns and variations of specific health outcomes relevant to HCQIP. The MQMS is designed to fully address issues of disease-specific health status and outcomes of care at the State level, and is relevant to program improvement and accountability of the HCQIP.

Status: HCQIP initially focused on acute myocardial infarction (AMI); however, CMS expanded its national quality improvement activities and is focusing on six clinical priority areas: AMI, breast cancer, diabetes, heart failure, pneumonia, and stroke.

98-251 Measurement, Indicators, and Improvement of the Quality of Life in Nursing Homes

Project Officer: Mary Pratt
Period: June 1998–May 2002
Awardee: University of Minnesota, School of Public Health
Funding: $2,766,715

Description: This project evaluates the impact of providing additional knowledge and educational tools on the improvement of quality of life for nursing home residents. It will focus on three topics: 1) measuring and developing indicators of quality of life, 2) developing quality improvement programs for nursing home quality of life, and 3) evaluating environmental design influences on quality of life.

The 11 domains initially tested include: autonomy, dignity, individuality, privacy, enjoyment, meaningful activity, physical comfort, relationships, security, functional competence, and spiritual well-being.

Status: Data analysis is underway to examine the inter-temporal and inter-rater reliability of the measures, test the transferability of the measures to nursing home personnel, and develop and test indicators of quality of life in nursing homes. In addition, the project is developing reliable ways to describe and classify features of the physical environment in nursing homes so as to study how physical environments affect quality of life.

99-121 National Resource Center on Home and Community Based Services - Quality Under Home and Community Based Waiver

Project Officer: Thomas Shenk
Period: September 1999–September 2002
Awardee: MEDSTAT Group (DC)
Funding: $3,463,070

Description: The purpose of this project is to develop and test the effectiveness of a National Consortium and Resource Center (NCRC) to improve access to consumer responsive home and community-based long-term care for people with disabilities of all ages. During a 24-month development period, this project focused on two related activities that could become the core of a fully operational NCRC. First, project staff will explore the effectiveness of a variety of national and State level strategies for supporting collaborative planning and problem solving among various stakeholders who influence the direction of long-term care policy reform (including Federal and State policy officials, representatives of the aging and disability community, and providers). Second, they will try out several different approaches to equipping the various stakeholders with the information, tools, and technologies they need to plan and implement cost-effective systems of consumer-responsive home and community-based services.

Status: In addition to the basic activities, this project also has five significant sub-activities: 1) creation of a national inventory of quality improvement, 2) development of systems and procedures for the collection, analysis, and management of long-term care data, 3) performance measurement for the quality of care, 4) research on the availability and adequacy of personal assistance services, and 5) collection, analysis and dissemination of promising practices.

97-264 Research and Analytic Support for Implementing Performance Measurement in Fee-for-Service

Project Officer: Peggy Parks
Period: September 1997–April 2002
Awardee: Health Economics Research
Funding: $1,151,985

Description: The goal of this project is to provide comparable information regarding performance in managed care and fee-for-service (FFS) programs. The project evaluated performance measurement at the national and small geographic area levels and practitioner-specific performance measurement at the group practice level. The small areas correlate with managed care market service-area definitions. Five small geographic areas were selected in Arizona, Georgia, Pennsylvania, Wisconsin, and Washington. Within those small geographic areas, four group practices agreed to participate in this project as our study partners. The study partnerships assisted us in exploring the feasibility of producing these measures at the group practice level.

Status: The project is nearly completed. In 2002, the contractor will submit reports on the Health Outcomes Survey in Medicare Fee for Service and a comparison of it with the Health Outcomes Survey in Managed Care. A report on how responses to the survey can be biased was recently submitted.

00-065 Clinical and Economic Effectiveness of a Technology-Driven Heart Failure Monitoring System

Project Officer: John Pilotte
Period: September 2000–September 2004
Awardee: University of Pennsylvania, Heart Failure and Cardiac Transplant Program
Funding: $1,688,453

Description: This demonstration project assesses the impact of the Alere DayLink Heart Failure Monitoring System on the clinical outcome and economic effect among Medicare beneficiaries recently hospitalized for heart failure or acute exacerbation of previously existing heart failure. The project first looks at the addition of the Alere DayLink Heart Failure Monitoring System to standard management of heart failure medical care impact on re-hospitalizations for heart failure over six months. Second, the project will analyze the impact of the monitoring system on utilization of other Medicare services, Medicare costs, functional status, processes of care, physician adherence to recommended clinical care guidelines, patient adherence with prescribed therapy, social support, and patient acceptance and satisfaction. Patients initially randomized to this technology will be re-randomized to either an additional 6 months of monitoring or to standard heart failure medical care with discontinuation of the Alere telemonitoring to assess the persistence of the intervention's effectiveness. Third, analysis will explore the impact of the extended six months of this monitoring system on re-hospitalization rates for heart failure, utilization of Medicare services, Medicare costs, patient adherence to the prescribed medical regimen, and functional status. Thus, the demonstration will assess the impact of this technology on a range of clinically and policy relevant heart failure outcomes.

Status: Four hundred and forty Medicare beneficiaries, recently hospitalized for management of new onset heart failure or an acute exacerbation of previously existing heart failure, were enrolled at three geographical sites of different character: rural, (Billings Montana); small Metropolitan Statistical Area, (Louisville, Kentucky); and major Metropolitan Statistical Area, (Philadelphia, Pennsylvania).

01-171 Improving Nursing Home Enforcement

Project Officer: Elaine Lew
Period: September 2001–September 2003
Awardee: C.N.A. Corporation
Funding: $400,000

Description: This purpose of this project is to assess the effectiveness of enforcement as the primary public policy for ensuring nursing home quality and protecting residents. This study will assess the overall effectiveness of the survey and certification regulatory system, and identify specific policy issues and options for improvement.

Status: This newly initiated project is in the startup phase.

01-110 The Impact of Alternative Low Vision Intervention on Quality

Project Officer: Joel Greer
Period: August 2001–August 2003
Awardee: West Virginia Research Corporation, West Virginia University
Funding: $558,867

Description: This project tests interventions and improves the quality of life for individuals with low vision, with a particular focus on the elderly. The West Virginia University Research Corporation is creating a regional center for vision rehabilitation services, the Appalachian Center for Visual Rehabilitation. This center will serve the low vision needs of a statewide rural community, evaluate the effectiveness of its programs, and export the beneficial ones to other rural areas across the country.

Status: This project was mandated by (fiscal year 2001) Appropriations legislation.

01-109 State Licensure and Certification Standards and Respiratory Therapy Competency Examinations

Project Officer: Tamara Syrek
Period: July 2001–July 2002
Awardee: Barents Group
Funding: $278,491

Description: The purpose of this project is to prepare CMS to submit a report to Congress that examines whether the Medicare program should require competency exams or certification for those providing respiratory care in skilled nursing facilities. This project is to study and identify variations in State licensure and certification standards for health care providers (including nursing and allied health professionals) and other individuals providing respiratory therapy in skilled nursing facilities. It is also to examine State requirements relating to respiratory therapy competency examinations for these providers and individuals.

Status: The project is on target to receive the final report that will be submitted to Congress by March 2002.

01-212 Improving Medication Safety in Outpatients Through Improved Packaging

Project Officer: Dennis Nugent
Period: September 2001–July 2004
Awardee: Ohio State University Research Foundation
Funding: $691,000

Description: The general intent of this project is to improve the safety of medication use. The object is to identify strategies that will directly reduce the frequency of medication errors where patient compliance with medication instructions is critical. This particular study will focus on the impact of packaging/distribution systems and patient education on compliance, treatment outcomes and frequency of adverse drug events. Three sites are used to assure an adequate sample size. Sampled patients will be those with a diagnosis of hypertension getting prescriptions for lisinopril. After agreeing to participate, patients are randomly assigned to a study or control group. The study groups' medications are packaged in "unit of use" with special instructions; the control group gets the standard package with the usual labeling. Compliance is measured by interview, pill counts, refill regularity and blood pressure. Morbidity (angina, myocardial infarction, stroke, renal impairment) and mortality will be measured. Medical service utilization (emergency department visits, hospitalizations) will be compared. Enrollment will occur for six months and each patient will be followed for six months.

Status: This continues earlier work of this awardee to explore adverse drug events in outpatients.

01-267 Asthma Champion Initiative

Project Officer: Cheryl Austein-Casnoff
Period: June 2001–May 2002
Awardee: Cook County, Bureau of Health Services
Funding: $350,000

Description: This demonstration is an attempt to reduce morbidity and mortality from asthma in high prevalence areas. The project will create two centers of clinical learning in model asthma care. It will develop culturally-appropriate educational materials and train a cadre of practicing providers in the area where asthma is highly prevalent. It will also supply intensive intervention with patients who receive emergency department services for asthma and will assess the practice sites of trained providers (Asthma Champions). This is hoped to lead to an integration of the Asthma Champion approach with related activities in the Chicago area.

Status: The project is newly underway.

01-264 Innovations in Health Care

Project Officer: Dennis Nugent
Period: September 2001–September 2002
Awardee: Duke University, Health System
Funding: $775,833

Description: This is a three-phase study. First, it will develop policy case studies in strategic health planning designed to highlight the importance of integrative disease management and strategic health planning for patients with three complex and chronic diseases (congestive heart failure, diabetes, and depression). A policy case study on the management of obstetric care at the time of delivery will also be conducted. The second will summarize the evidence and develop an evidence-based approach to patient-specific strategic health planning that services to link risks and behaviors to action items unique for each patient independent of any particular disease. The plans will incorporate a broad-based integrative approach including strategies regarding nutrition, exercise, stress management, and social support. The project will then implement strategic health planning in a defined patient cohort. Finally, the project will be a cost and policy analysis of secondary prevention for patients with coronary artery disease. The objectives here will be to maximize the appropriate use of secondary prevention for this disease in Medicare patients; measure the financial impact on hospitals, providers, and patients of improving secondary prevention; and examine the effectiveness of strategies to improve adherence of physicians and patients to secondary prevention.

Status: The project is newly underway.

01-277 Study on Medicare Coverage of Routine Thyroid Screening

Project Officer: Katharine Pirotte
Period: September 2001–March 2003
Awardee: National Academy of Sciences, Institute of Medicine
Funding: $450,000

Description: This is a study on the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit under Medicare. This is a mandated study [section 123 of the Benefits Improvement and Protection Act of 2000]. The mandate also requires that this involve the Academy's United States Preventive Services Task Force. The study is to consider the short-term and long-term benefits and the cost to the Medicare program of such an additional benefit.

Status: The project is newly underway.

02-078 Develop, Conduct and Analyze Surveys of Quality Improvement Organization (QIO) Customers

Project Officer: Craig Schneider
Period: September 2002–March 2005
Awardee: Westat Corporation
Funding: $465,046

Description: The purpose of this project is to conduct customer satisfaction surveys in each State regarding the quality of care complaint process. Hospitals, physicians, home health agencies, nursing homes, Medicare+Choice organizations, and beneficiaries will be surveyed. The survey will be administered at approximately the halfway point of CMS' contract with the Quality Improvement Organizations (QIO) contract. QIOs are divided into three contracting groups known as "Rounds."

Status: Round One QIOs begin their three-year contracts in August 2002, Round Two in November 2002, and Round Three in February 2003.

01-257 National Initiative for a Long-term Care Workforce of Paraprofessionals

Project Officer: Karen Tritz
Period: July 2001–December 2002
Awardee: Office of the Assistant Secretary for Planning and Evaluation
Funding: $300,000

Description: This provides support for a project to develop a national initiative for a qualified, committed and stable long-term care workforce of paraprofessionals (home health aides, nurse assistants, personal care assistants). This initiative will contain four elements: State and local innovation grants, an applied research program, an awareness and education campaign, and an information clearinghouse on workforce innovation.

Status: This is a newly established project in its startup phase.

01-259 Evidence Report on Routine Thyroid Screening

Project Officer: Katharine Pirotte
Period: September 2001–June 2002
Funding: $50,000
Awardee: Agency for Healthcare Research and Quality

Description: This project is an evidence report on routine thyroid screening using the thyroid stimulating hormone test (TSH). This report is to be developed by the Evidence-based Practice Center. Medicare cannot pay for preventive services unless such has been added by law. We are interested in expanding the current preventive services offered by Medicare. The Benefits Improvement and Protection Act requires that we obtain a study from the National Academy of Sciences and the U.S. Preventive Services Task Force on the addition of coverage for routine thyroid screening using the TSH test. This study is to consider the short and long term benefits as well as the costs of such an additional preventive benefit. This project will involve 1) research and systematic review of clinical evidence of this screening, including its efficiency and effectiveness as it applies to the Medicare population, 2) the identification of sub-populations at greatest risk, 3) an assessment of potential benefits of routine screening, and 4) a syntheses of the evidence to provide the foundation for the development of evidence-based recommendations.

Status: This project is in the early stages.

00-175 Evaluation of Independent Informal Dispute Resolution Process (IDR)

Project Officer: Elaine Lew
Period: September 2000–September 2003
Awardee: Kathpal Technologies
Funding: $973,052

Description: The project evaluates the effectiveness of the current and independent informal dispute resolution (IDR) process in order to ascertain whether revisions need to be made to Federal procedures as it relates to institutional long-term care. The current process gives a nursing home the opportunity to informally dispute survey findings to the State Survey Agency following the receipt of the Statement of Deficiencies. This is a nursing home's first opportunity for such a challenge and, while this initial step is informal, the decisions are binding. However, since the individuals who approve of the survey findings are sometimes the same ones who review IDR cases, the process is often viewed as not objective. This project responds to a recommendation in a Congressional Appropriations Committee Report (fiscal year 2000) for CMS to initiate a pilot study using an independent entity to conduct the nursing home IDR process.

Status: Two States (Iowa and Texas) are participating in CMS's independent IDR pilot study. For the duration of the study, these States will replace their current IDR process with an IDR process conducted by an entity outside of the State Survey Agency. The contractor is now collecting information from the two pilot States to establish baseline data from which to compare. They are also meeting with staff from the State Survey Agencies, as well as the State provider organizations and advocates, to capture their perceptions of the current IDR process.

01-221 Northern New England Vascular Surgery Quality Improvement Initiative

Project Officer: Jackie Kennedy-Sullivan
Period: September 2001–September 2003
Awardee: Dartmouth University
Funding: $650,000

Description: The goal of this project is to improve the care of patients undergoing vascular surgery in Maine, New Hampshire and Vermont. A data registry will be used to collect detailed clinical information on patient care. A risk-adjustment model will be developed to analyze the outcomes of care. Outcomes reporting and benchmarking visits will be used to improve outcomes and reduce variations in care delivery.

Status: This project is in the startup phase.

94-074 Design and Implementation of Medicare Home Health Quality Assurance Demonstration

Project Officer: Armen Thoumaian
Period: September 1994–December 2003
Awardee: Center for Health Policy Research, University of Colorado
Funding: $5,185,699

Description: The Medicare Home Health Quality Assurance Demonstration has developed and tested an approach to develop outcome-oriented quality assurance techniques and promote continuous quality improvement in home health agencies (HHA). The goal of the demonstration was to determine the feasibility of a methodology for a national approach for outcome-based quality improvement (OBQI). Outcome measures were computed using the Outcomes and Assessment Information Set (OASIS). Under the demonstration, staff of 54 regionally dispersed HHAs completed the OASIS data collection instrument for each patient at the start of care and at 60-day intervals (up to and including discharge). CHSR then conducted three rounds of data analysis and outcome report generation, each based on 12 months of data. Risk adjusted reports are produced for 41 specific patient quality outcomes for all adult patients. These reports are provided to the participating HHAs and are used to determine which outcomes need improvement, thereby providing a focus for agency staff to target problematic care. The demonstration resulted in significant improvement in 80 percent of agency-specific outcome targets, with a yearly improvement in re-hospitalization rates across all agencies.

Status: Fifty-four agencies in 26 States were phased into the demonstration beginning in January 1996. In January 1997, the demonstration agencies received their first outcome reports and developed plans of action to improve care for two patient outcomes during 1997. Agencies received their second annual reports in May 1998, which contained baseline comparisons from 1997, and received their third and final reports in May 1999. A final report has been completed and is available. Funding was increased to a total of $5,185,000 and the project was extended 3 years to December 2003.

98-257 Development and Validation of Measures and Indicators of the Quality Appropriateness of Services Rendered in Post-Acute and Long Term Care Settings

Project Officer: Yael Harris
Period: September 1998–September 2003
Awardee: Abt Associates
Funding: $5,247,965

Description: This project is developing and validating a comprehensive set of performance measures and indicators of quality for institutional post-acute and long-term care settings. The post-acute settings involved include skilled nursing facility short-stay units, inpatient rehabilitation facilities (which include hospital-based rehabilitation units), and long-term care hospitals. Performance measures will be standardized across provider types, in order to allow necessary comparisons to be made about outcomes of care. Performance measures may also be used within CMS' regulatory quality monitoring programs to inform quality improvement activities, to provide information to consumers, and to provide information to payers of health care for use in evaluating the quality and care delivery. The use of quality measures and indicators, such as those to be developed under this project, will allow CMS to determine objectively the value of the care it purchases by providing a valid measurement of the care furnished by Medicare-participating providers.

Status: Based on the comments and feedback received, a final set of nine new long term care QIs and eight post-acute QIs were developed. The team is currently involved in the validation of these measures as well as preparing 11 of these measures (9 long term care indicators and 4 post acute indicators) for Public reporting in 6 pilot States beginning in April 2002. A set of measures is expected to be posted on Medicare.gov for all nursing homes in the U.S. beginning October 2002.

Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI System

The goal of this pilot project is to explore the feasibility of establishing a national home health outcome based quality improvement (OBQI) system. Quality Improvement Organizations (QIOs, formerly known as Peer Review Organizations or PROs) work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies. The QIOs provide a supportive role to HHAs in their endeavors to comply with Medicare Conditions of Participation, assist the State agencies in related monitoring and enforcement efforts, assist CMS and Regional Home Health Intermediaries (RHHIs) in home health program integrity assessment, and prepare summary information about the Nation's home health care. Major objectives include: develop training materials for the pilot QIOs and HHAs about the Outcome and Assessment Information Set (OASIS), OASIS outcome reports, OASIS based quality improvement programs; assist the other pilot PROs to provide OBQI training and/or consultation to the HHAs in their State, to State agencies, and CMS; provide regular assessments of local, regional and national home health services, create a clearing house to distribute information about best practices in home health; develop materials for Medicare beneficiaries to facilitate proper interpretation of home health outcome reports; and perform special studies to assist in CMS quality improvement, program integrity and medical review efforts in HHAs. Although State agencies will be responsible for generating State aggregate information using agency-specific reports, a mechanism has not been developed to provide support to the HHAs to develop and manage quality improvement programs.

00-012 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI System PRO

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Delmarva Foundation for Medical Care
Funding: $1,365,517

Status: In progress.

00-013 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI Pilot PRO - Maryland

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Delmarva Foundation for Medical Care
Funding: $178,000

Status: The Maryland Peer Review Organizations (PRO) will work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies.

00-014 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI Pilot PRO - New York

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Island Peer Review Organization
Funding: $690,000

Status: The New York QIOs assist the State agencies in related monitoring and enforcement, work with home health agencies (HHAs) to implement quality improvement programs, and provide consultation to CMS, its contractors, and State agencies.

00-015 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI Pilot PRO - Michigan

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Michigan Peer Review Organization
Funding: $652,000

Status: The Michigan QIOs work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies.

00-016 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI Pilot PRO - Rhode Island

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Rhode Island Quality Partners
Funding: $450,000

Status: The Rhode Island QIOs work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies.

00-017 Home Health Outcome Based Quality Improvement System Pilot Demonstration - HH OBQI Pilot PRO - Virginia

Project Officer: Armen Thoumaian
Period: December 1999–March 2002
Awardee: Virginia Health Quality Center
Funding: $474,000

Status: The Virginia QIOs work with home health agencies (HHAs) to implement quality improvement programs and provide consultation to CMS, its contractors, and State agencies.

01-211 Integrated Chronic Disease Quality Performance Measurement at the Physician Level

Project Officer: Barbara Fleming
Period: September 2001–March 2004
Awardee: C.N.A. Corporation
Funding: $499,999

Description: This project is to assist CMS in exploration of the issues important to physician level quality of care scoring in chronic disease and prevention. The project will help to define quality of care for chronic disease using existing performance measures and will use existing data to begin to model these concepts. Performance measurement supports CMS program management and policy development purposes, such as quality improvement in the QIO program, demonstration of accountability, and value-based purchasing. Several of our projects have attempted to integrate broader chronic disease-based thinking into their measurement structure (i.e., the Diabetes Quality Improvement Project or DQIP, the Study of Clinically Relevant Indicators of Pharmacologic Therapy or SCRIPT, and the Ambulatory Care Quality Improvement Program or ACQIP). The ACQIP data will be the primary vehicle for the initial work. The second phase applies knowledge gained in diabetes care quality measurement to develop a framework and model for composite quality of care scoring for chronic disease.

Status: This project is in the startup phase.

01-118 Improved Protocols for Home Health Agency Assessment in the Survey Process

Project Officer: Tracey Mummert
Period: September 2001–March 2004
Awardee: Center for Health Policy Research, University of Colorado
Funding: $797,000

Description: The purpose of this project is to assess the existing home health agency (HHA) survey process and make recommendations for improvements. Improvements include patient-focused, outcome-

oriented, data-driven approaches that are effective and efficient in assessing, monitoring and evaluating the quality of care delivered by an HHA. The project will also evaluate the effectiveness of current survey forms, develop new survey forms, as applicable, and make recommendations for prioritizing onsite survey time. The assessment will focus on the Outcome and Assessment Information Set (OASIS), designed for the purpose of enabling the rigorous and systematic measurement of patient home health care outcomes, with appropriate adjustment for patient risk factors affecting those outcomes; and the Online Survey Certification and Reporting System (OSCAR).

Status: The period of performance was extended to June 2004. To date, several States have volunteered to participate in the testing of the new survey protocols.

01-268 Ultrasound Screening for Abdominal Aortic Aneurysms

Project Officer: William Saunders
Period: September 2001–September 2002
Awardee: Dartmouth University
Funding: $500,000

Description: The objectives of this project are to determine the feasibility and benefit of ultrasound screening to detect abdominal aortic aneurysm in Medicare beneficiaries. It will determine the prevalence of such aneurysms in the screened population, evaluate the cost of developing and maintaining an ultrasound screening program to detect these aneurysms and determine the cost-effectiveness of screening Medicare patients.

Status: This award was directed by the FY2001 Appropriation bill, PL 106-554.

01-170 Development of Quality Indicators for Inpatient Rehabilitation Facilities

Project Officer: Lisa Hines
Period: September 2001–September 2003
Awardee: Research Triangle Institute, (NC)
Funding: $1,420,000

Description: The purpose of this project is to support developing and defining measures to monitor the quality of care and services provided to Medicare beneficiaries receiving care in inpatient rehabilitation facilities. It will identify the elements integral to assessing quality of care in rehabilitative services and developing a set of measures for use by States.

Status: The period of performance was extended to June 2004. To date, several States have volunteered to participate in the testing of the new survey protocols.

01-289 Northern New England Vascular Surgery Quality Improvement Initiative - II

Project Officer: Sheila Roman
Period: September 2001–September 2002
Awardee: Dartmouth University
Funding: $500,000

Description: The goal of this study is to improve the care of patients undergoing vascular surgery. Data will be collected regarding indications, comorbidities, operative details and outcomes for vascular surgery, including abdominal aortic aneurysm repair. A risk adjuster model will be developed. The study will use a cooperative clinical data registry, benchmarking visits by clinicians, comparative process analysis, and continuous quality improvement to improve outcomes and reduce variation in care delivery.

Status: This award was directed by the FY2001 Appropriation bill, PL 106-554.

01-221 Northern New England Vascular Surgery Quality Improvement Initiative - I

Project Officer: Beth Kosiak
Period: September 2001–September 2003
Awardee: Trustees of Dartmouth College, Office of Grants and Contracts
Funding: $262,000

Description: The goal of this project is to improve the care of patients undergoing vascular surgery in Maine, New Hampshire and Vermont. A data registry will be used to collect detailed clinical information on patient care. A risk-adjustment model will be developed to analyze the outcomes of care. Outcomes reporting and benchmarking visits will be used to improve outcomes and reduce variations in care delivery.

Status: This project is in the startup phase.

02-081 Construction of Analytic Files for Study of the Cardiac Rehabilitation Benefit Among Medicare Beneficiaries

Project Officer: Rosemarie Hakim
Period: September 2002–March 2003
Awardee: CHD Research Associates
Funding: $39,997

Description: The purpose of this task order is to provide programming support for the development of analytic files that will be used to determine whether use of cardiac rehabilitation has a health benefit on Medicare beneficiaries as evidenced by a reduction in adverse outcomes including hospitalizations, use of home health or long-term health services, or death. The study requires longitudinal files based on a cohort of Medicare beneficiaries who were candidates for cardiac rehabilitation from January 1995 through December 1996. All medical treatment received by this cohort will then be followed up for a period of up to 5 years subsequent to entry into the cohort.

Status: Currently in AGG 4/1/02.

02-056 Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries

Project Officer: William Buczko
Period: September 2002–September 2005
Awardee: Urban Institute
Funding: $649,958

Description: This project studies longitudinal patterns of care of elderly beneficiaries with likely long-term care needs and the progress of groups of beneficiaries with similar health/functional status who remain in the community or who move from the community to institutional settings, as well as within institutional settings. It will develop a research model and conduct studies based on this model to assess the progress of beneficiaries with similar medical conditions, functional status, and long-term care needs through the health care delivery system. It will address key factors influencing the delivery of care such as insurance coverage, types of services used, processes leading to institutionalization, and costs of care.

98-276 Healthy Aging/Smoking Cessation

Project Officer: James Coan
Period: October 1998–September 2004
Awardee: RAND Corporation
Funding: $200,000

Description: This demonstration will test smoking cessation as a Medicare benefit, based on RAND's Healthy Aging Project evidence report on smoking cessation and the Public Health Service clinical guideline on treating tobacco use and dependence. The demonstration will compare the impact of offering three different types of benefits for smoking cessation services on "quit" rates. The benefit options are:
1) reimbursement for provider counseling only;
2) reimbursement for provider counseling, in addition to FDA-approved prescription or nicotine replacement therapy; and 3) telephone counseling quit-line and reimbursement for nicotine replacement therapy; and 4) usual care (smoking cessation information). States participating in the demonstration are Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska, and Wyoming.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Status: Legislation is required to add a smoking cessation benefit in Medicare. The Office of Management and Budget (OMB) agreed to the waiver, which permits these demonstrations to operate in January 2001.

01-217 Healthy Aging/Smoking Cessation

Project Officer: James Coan
Period: August 2001–February 2002
Awardee: Olgivy, Seniors Research Group
Funding: $253,275

Description: This demonstration is a part of the Healthy Aging Project and is intended to test potential interventions for smoking cessation that may be offered as a Medicare covered benefit to beneficiaries who smoke. The following variations in a smoking cessation benefit will be tested: 1) provider counseling reimbursement only, 2) provider counseling reimbursement with bupropion or nicotine replacement pharmacotherapy coverage, 3) Quitline and nicotine replacement pharmacotherapy coverage, and 4) usual care. The specific goals of the Medicare Stop Smoking Program are to evaluate the effectiveness, feasibility, and cost of the smoking cessation benefit strategies in seven States and to make inferences that are generalizable to the Medicare program.

Status: The States participating in the demonstration are Alabama, Florida, Missouri, Nebraska, Ohio, Oklahoma, and Wyoming.

96-050 Influenza and Pneumococcal Analytic Reports

Project Officer: Lawrence LaVoie
Period: September 1996–January 2002
Awardee: CHD Research Associates
Funding: $698,924

Description: This project develops a research data base using CMS Medicare claims data to study the epidemiology of influenza (flu) and pneumococcal vaccination (PPV). One goal is to promote vaccinations by health-care providers, and to support coverage for Medicare beneficiaries. For example, Medicare claims records for PPV are extracted and merged to create a beneficiary-level PPV research file used to generate annual and cumulative immunization rates. Using both the PPV file and flu immunization data file, a series of national and State-specific statistics are produced. Medicare utilization and enrollment data are linked with the PPV and flu files data to analyze immunization rates of high-risk beneficiaries.

Status: A PPV research file update with 2000 Medicare claims has been completed. National and State-specific statistics, based on analysis of 1999 Medicare claims, have been published in tables and reports and posted on CMS's web site.

96-219 Medicare State Health Profile

Project Officer: Paul Elstein, Benedicta Abel-Steinberg
Period: September 1996–April 2002
Awardee: RAND Corporation
Funding: $2,146,988

Description: This project analyzes claims data at the State level and enhances data with additional diagnosis-specific analyses and analyses of inpatient encounter data from Medicare+Choice organizations, focusing on four clinical priority areas (acute myocardial infarction (AMI), heart failure, diabetes, breast cancer, pneumonia, and stroke/ transient ischemic attack). CMS contracts with Quality Improvement Organizations (QIO, formerly peer review organizations) in each of the 50 States, and in the District of Columbia, Puerto Rico, and the Virgin Islands. QIOs are focusing on quality outcomes through the Health Care Quality Improvement Program (HCQIP). The outcome measures for the clinical areas include mortality and re-admissions, and data sources include claims, medical records, and surveys.

Status: Analyses are available from the CMS web site.

00-120 Implementation of Quality Improvement Organization 6th Scope of Work Pneumococcal Pneumonia and Influenza Immunization Remeasurement Survey

Project Officer: Susan Arday
Period: September 2000–November 2002
Awardee: Abt Associates
Funding: $1,542,230

Description: This project specifically implements the Pneumococcal Pneumonia and Influenza Immunization Remeasurement Survey. The goal is to assess the utilization of influenza and pneumococcal vaccines among Medicare beneficiaries, and to evaluate the vaccine promotion work performed by Quality Improvement Organizations (QIO, formerly Peer Review Organizations) under their Medicare sixth Scope of Work. The survey is administered to a sample of Medicare beneficiaries randomly selected from each of 50 States plus the District of Columbia and Puerto Rico, and will produce the attendant State-specific rates.

Status: There are two separate, sequential rounds of data collection. All data collection and delivery for the first round was completed by June 2001. The second round of the survey data collection was completed June 2002.

01-220 Heart Failure Home Care

Project Officer: John Pilotte
Period: September 2001–September 2004
Awardee: University of Pittsburgh, Office of Research
Funding: $1,847,941

Description: This project seeks to use integrated nursing services and technology to implement daily monitoring of congestive heart failure patients in under-served populations in accordance with established clinical guidelines. The demonstration tests the clinical and economic effectiveness of the Alere Day Link Home Monitoring Device in Medicare beneficiaries from under-served population groups receiving care in community-based practices who are diagnosed with congestive heart failure and who have had a hospitalization within the last 6 months. The primary hypothesis is that the addition of this device to standard management of heart failure will reduce 6-month heart failure hospitalization rates, cardiovascular death, and decrease length of hospital stay for heart failure.

Status: This newly initiated project is in the startup phase.

00-053 Medicare Lifestyle Modification Program Demonstration Evaluation

Project Officer: Armen Thoumaian
Period: September 2000–August 2005
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,995,144

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 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; and the use of systems for administration, claims processing and payment, and the routine monitoring of quality of care.

Status: In September 2001, the evaluation was expanded to include a longer followup period of treatment and control patients and to include a critical review of literature. Preparations are being made to begin efforts to find Medicare beneficiaries that can be

matched to those receiving treatment and followed as controls. We are awaiting final OMB approval of the beneficiary and provider survey instruments. The evaluation team has completed initial site visits and submitted a site visit report with recommendations.

99-136 Medicare Lifestyle Modification Program Demonstration Continuous Quality Monitoring

Project Officer: Mary Pratt
Period: July 1999–September 2003
Awardee: Delmarva Foundation for Medical Care
Funding: $639,215

Description: This project provides the quality monitoring for a 4-year payment demonstration designed to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating sites licensed by the Dr. Dean Ornish Program for Reversing Heart Disease®, and is being expanded to include facilities licensed to provide the Cardiac Wellness Expanded Program of Dr. Herbert Benson and the Mind Body Medical Institute. Sites under each model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. Claims processing and payment are managed through the Demonstrations Management Branch in the Office of Financial Management. This project provides continuous quality monitoring of the demonstration sites to help assure the health and safety of the participating Medicare patients.

Status: The period for the demonstrations commenced on October 1, 1999. On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate the lifestyle program of the Mind/Body Medical Institute (M/BMI) into the demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. DelMarVa continues to provide the quality monitoring for the demonstrations, as modified.

Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute

The Medicare Lifestyle Modification Program Demonstration is a 4-year payment project implemented to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating sites licensed by the Dr. Dean Ornish Program for Reversing Heart Disease®. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites will receive 80 percent of a total negotiated fixed payment amount for a 12-month program. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Demonstrations Management Branch in the Office of Financial Management.

Status: On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate a second lifestyle program operated by the Mind/Body Medical Institute (M/BMI) into the overall demonstration.

01-236 Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute – Kearney, Nebraska

Project Officer: Armen Thoumaian
Period: June 2001–September 2003
Awardee: Good Samaritan Hospital, Health Lifestyle Program
Funding: $0

00-178 Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute – Rockford, Illinois

Project Officer: Armen Thoumaian
Period: May 2000–September 2003
Awardee: Swedish American Center for Complementary Medicine
Funding: $0

01-235 Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute – Bloomington, Indiana

Project Officer: Armen Thoumaian
Period: January 2001–September 2003
Awardee: BroMenn Healthcare, Department of Cardiology
Funding: $0

00-177 Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Pittsburgh

Project Officer: Armen Thoumaian
Period: July 2000–September 2003
Awardee: Highmark Blue Cross/Blue Shield
Funding: $0

00-176 Medicare Lifestyle Modification Program Demonstration - Preventive Medicine Research Institute - Omaha

Project Officer: Armen Thoumaian
Period: July 2000–September 2003
Awardee: Alegent Health, Immanuel Medical Center
Funding: $0

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute

The Medicare Lifestyle Modification Program Demonstration is a 4-year payment project implemented to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. The demonstration is being implemented at participating facilities licensed to provide the Cardiac Wellness Expanded Program of Dr. Herbert Benson and the Mind Body Medical Institute. Sites under this model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites will receive 80 percent of a total negotiated fixed payment amount for a 12-month program. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Demonstrations Management Branch in the Office of Financial Management.

Status: On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, steps have been completed to incorporate this lifestyle program of the Mind/Body Medical Institute (M/BMI) into the overall demonstration.

01-237 Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute – Boston

Project Officer: Armen Thoumaian
Period: June 2001–November 2004
Awardee: Beth Israel Deaconess Medical Center
Funding: $0

01-238 Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute – Warwick, Rhode Island

Project Officer: Armen Thoumaian
Period: September 2001–November 2004
Awardee: Care New England Wellness Center
Funding: $0

01-239 Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - South Bend, Indiana

Project Officer: Armen Thoumaian
Period: August 2001–November 2004
Awardee: St. Joseph Regional Medical Center
Funding: $0

02-020 Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Nashville

Project Officer: Armen Thoumaian
Period: December 2001–November 2004
Awardee: Baptist Hospital System, Cardiac Wellness Program
Funding: $0

02-021 Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute - Houston

Project Officer: Armen Thoumaian
Period: November 2001–November 2004
Awardee: Memorial Hermann Southwest Hospital
Funding: $0

02-057 Outcome and Assessment Information Set (OASIS) Technical Analysis & Support Contract

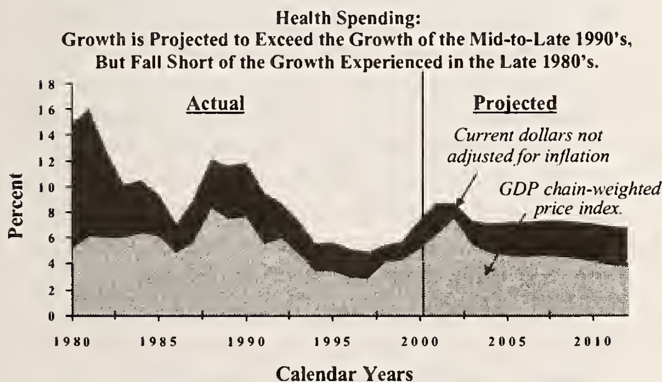
Project Officer: Armen Thoumaian
Period: September 2002–September 2006
Awardee: Center for Health Services Research (formerly: Center for Health Policy Research) University of Colorado–Health Sciences Center
Funding: $1,099,982

Description: The purpose of this contract is to provide technical analysis and consultation in support of the CMS objective to provide information that can be used to improve home health quality of care and to provide public reporting about home health quality of care outcomes. The project will design and implement a data analysis system to provide information on a regular basis for the public reporting effort. Home health outcome information is derived from the analysis of data obtained from the collection and reporting by home health agencies (HHAs) of patient assessment information using the Outcome & Assessment Information Set (OASIS).

Status: In startup phase.

Theme 8: Building Research Capacity

CMS' research budget supports a variety of activities to increase the efficiency of our research and demonstration program and to meet the crosscutting research needs of the wider health research community. These activities include assisting the infrastructure of health services research and providing tools to support CMS' research program. One example is the Research Data Assistance Center (ResDAC) that was developed to assist new researchers in developing familiarity and use of CMS' massive databases for research on Medicare and Medicaid issues. Another example is the Medicare Current Beneficiary Survey (MCBS)—the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. CMS is also building research capacity through demonstration projects to develop, implement, and evaluate a culturally-sensitive, multi-faceted pilot program that seeks to improve disease screening knowledge, attitudes, and health care practices in a high risk population of poor and elderly minority populations.



Source: CMS, Office of the Actuary, National Health Statistics Group.

96-049 Tabulate Data from the National Employer Health Insurance Survey

Project Officer: Katharine Levit
Period: September 1996–February 2002
Awardee: CHD Research Associates
Funding: $130,572

Description: This project supports a range of programming, analytical, and statistical application skills needed for a wide range of tasks related to research activities. This task explores and tabulates data from the National Employer Health Insurance Survey and other surveys. The aim is to produce basic descriptive data on private health insurance. These data provide the basis for the "private health insurance" accounts within the national, State and age-based health accounts.

Status: Project extended through February 2002.

97-014 Hospital Cost Monitoring

Project Officer: Benson Dutton
Period: April 1997–January 2003
Awardee: American Hospital Association
Funding: $692,330

Description: The purpose of this project is to replace the data collected by the American Hospital Association (AHA) through the National Monthly Hospital Panel Survey (NMHPS) with the National Hospital Indicators Survey (NHIS). These data will be used for research, actuarial studies and policy development efforts that involve cost, expenditure, service and utilization analyses. The AHA annually collects data on hospitals using the NMHPS and NHIS. The quarterly hospital survey summary statistics (national by Census division and by AHA bed size) contain information on items such as: hospital beds, inpatient and outpatient utilization, revenue and expenses, and utilization for inpatients 65 years old and older.

Status: This is the fourth in a series commencing in 1980 (contract numbers 500-80-0066, 500-87-0039 and 500-92-0003). The annual survey of hospital data is delivered annually in December for the preceding year. Results through the 1st Quarter 2001 have been delivered.

97-025 Expansion of Special Policy Analysis Model (SPAM) - II

Project Officer: Sally Burner
Period: September 1997–September 2002
Awardee: Actuarial Research Corporation
Funding: $1,919,199

Description: This project continues the development of the micro-simulation model used to support health policy analyses begun under contract 500-92-0042 "Expansion of Special Policy Analysis Model." The model is used by CMS to analyze the impacts of changes in the U.S. health care financing and delivery system and to provide support for the expanded requirements resulting from the Health Insurance Portability and Accountability Act of 1996.

Status: The is a long-term support project for CMS' Office of the Actuary. The micro-simulation model is being continually updated. It is a working tool that is used on an on-going basis.

99-060 Programming Support for Development of the Surveillance, Epidemiology, and End Results (SEER)-Medicare Database

Project Officer: Gerald Riley
Period: June 1999–September 2002
Awardee: CHD Research Associates
Funding: $357,242

Description: This project provides programming support for the Surveillance, Epidemiology, and End Results (SEER)-Medicare data base. The SEER-Medicare data base 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 creation of the linked files requires matching persons reported to the SEER registries with a master file of Medicare enrollment to determine which persons appearing in the SEER data are entitled to Medicare. For persons found to be Medicare enrollees, their Medicare utilization claims are appended to their SEER record. The instant programming services are for the update and maintenance of the SEER-Medicare data, analyses related to the SEER-Medicare data, and analyses related to other Medicare program studies. CMS and NCI are both providing funds for this effort.

Status: The contractor has extracted Medicare claims data for 1999 and has obtained various Medicare files for a cancer-free control group. Plans are being formulated to update the SEER-Medicare link.

99-094 Improving Managed Care Outcomes Using Medicare Health Outcomes Survey Data

Project Officer: Sonya Bowen
Period: May 2000–October 2002
Awardee: Health Services Advisory Group
Funding: $1,529,185

Description: This project provides data cleaning, scoring, and performance profiling of (HOS) data collection. It trains managed care plans and Quality Improvement Organizations (QIO, formerly Peer Review Organizations) in the use of functional status measures and best practices for improving care. It also provides technical assistance for QIOs and plan interventions designed to improve functional status. Fiscal year 2002 will mark the release of HOS functional change scores for cohort 1 to plans, QIOs, and the public.

Status: The cohort 1 performance measurement reports were released to QIOs and plans in December 2001. A public release of data is expected in February 2002. Two-year functional status change scores and performance profiles for each plan have been developed from a merged cohort 1 baseline and remeasurement data set. Round 4 data submission, cleaning, and analysis from the 2001 HOS field administration will be completed in early 2002. Round 5 will be completed in late 2002. A national Quality Improvement System for Managed Care (QISMIC) pilot project, using HOS data to target beneficiaries at high risk for depression, continues. A conference is planned for the fall in Baltimore.

99-061 Programming Support for the Development of the Surveillance, Epidemiology, and End Results (SEER)-Medicare Database to Examine the Hospice Benefit among Aged Medicare Beneficiaries

Project Officer: Linda Greenberg
Period: September 1999–September 2002
Awardee: CHD Research Associates
Funding: $49,998

Description: This project provides programming services for the development of an analytic file of hospice services using the updated 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, the SEER registries, and CMS to create a large population-based source of information for cancer-related epidemiologic and health services research. The creation of the linked files requires matching persons reported to the SEER registries with a master file of Medicare enrollment to determine which persons appearing in the SEER data are entitled to Medicare. Preliminary analyses of the use of hospice services among elderly beneficiaries diagnosed with cancer suggest some differences by age, race, income, and HMO status. This project expands preliminary analyses beyond colorectal and lung cancer cases diagnosed in 1992 and 1993 to include more cases from the updated Medicare-SEER database. We will examine the sociodemographic determinants of hospice use among all decedent cancer patients, ages 65 and older, and expenditure patterns of users and nonusers of hospice care. Additionally, analyses will focus on differences among cancer patients enrolled in health maintenance organizations (HMO) and fee for service (FFS).

Status: The preliminary analyses have begun.

00-048 International Comparative Data and Analysis of Health Care Financing and Delivery Systems - II

Project Officer: Melvin Ingber
Period: August 2000–August 2005
Awardee: Organization for Economic Cooperation and Developoment
Funding: $379,325

Description: The Organization for Economic Cooperation and Development (OECD) has developed a unique database that contains information on health care financing and use in industrialized Western nations. This project obtains these data on an ongoing basis, updates and expands them, and provides a series of papers that analyze the trends in Western-developed nations and their policy relevance to the United States. These data are the source of statistics comparing health spending (usually expressed as a percentage of gross domestic product, or in U.S. dollars per capita) in the United States and other Western developed nations.

Status: The project is in progress and OECD has provided their last updated and enhanced database in CD-ROM format in August 2001. OECD will be providing the updated database in both CD-ROM and the Excel file format annually, in addition to the analytical papers, as approved under the contract budget.

96-221 Feasibility Study to Improve the Detection and Prevention of Duplicate and Near Duplicate Claims

Project Officer: Renee Hildt
Period: September 2001–May 2002
Awardee: Jing Xing Technologies
Funding: $49,993

Description: This is a project to write a requirements analysis that Medicare can use to prevent and detect duplicate and near duplicate claims. The project will also examine what would be necessary to implement them, obstacles that must be overcome, and the likelihood that implementing the requirements will reduce duplicate and near duplicate claims submission

and payment. The project must formulate a strategy that will focus on preventing duplicate and near duplicate claims submission, detecting duplicate and near duplicate claims once they have been submitted, and addressing duplicate and near duplicate claims once they are detected.

Status: This newly initiated project is in the startup phase.

01-234 Programming Support for Studies of the Medicare Disabled Population

Project Officer: Gerald Riley
Period: July 2001–July 2002
Awardee: CHD Research Associates
Funding: $39,945

Description: This project provides programming assistance to CMS in connection with the linkage of Medicare records to administrative data from the Social Security Administration. It also assists with the extraction of Medicare claims and enrollment data for beneficiaries in the linked sample. And, finally it helps build analytic files for studies of the disabled population.

Status: This newly initiated project is in the startup phase.

01-240 Econometric Forecasting and Economic Services - II

Project Officer: Shannon Martin
Period: April 2001–April 2006
Awardee: DRI
Funding: $350,000

Description: This project provides econometric forecasting and economic services. It also will provide forecasts of various CMS input price indexes for use in updating payments in the various PPS systems. The contract also provides for various other econometric and economic services.

Status: This project continues year-to-year since it provides basic support for our actuarial estimates used in operating the Medicare program. The previous contract was 500-96-0354 and was replaced after its 5-year term expired.

01-248 Data from National Rx Audit Databases - II

Project Officer: Jean Stiller
Period: September 2001–September 2002
Awardee: IMS America
Funding: $25,000

Description: This contract purchased data from the contractor's National Prescription Audit; total prescription counts, number of new prescriptions, number of refill prescriptions, pharmaceutical acquisition dollars and total retail dollars.

Status: Data were received on time.

01-249 Survey Result from the Retail Method of Payment Database - II

Project Officer: Jean Stiller
Period: September 2001–September 2002
Awardee: IMS America
Funding: $20,000

Description: This contract purchased data – retail sales of prescription drugs by State and by method of payment.

Status: Data were received.

01-261 Preparation of Analytic Data for the National, State, and Age Health Accounts Data Analysis

Project Officer: Anne Martin
Period: August 2001–August 2002
Awardee: Fu Associates
Funding: $40,000

Description: The National Health Accounts are produced annually to provide policy makers, analysts and researchers with historical information and projections about health care spending. These accounts include estimates of spending by service type (e.g., hospital care, physician services, nursing home care) and by broad funding source (e.g., Medicare, Medicaid, private health insurance). Periodically, health account estimates are also prepared by geographic area and by age cohort. As with the National Health Accounts, the State and age health accounts provide information useful in understanding and framing policy issues. This project prepares the data for the analyses.

Status: This project is in the early stages of data preparation.

01-266 Support for the Redesign of the Medicaid Statistical Information System

Project Officer: Al Celentano
Period: September 2001–September 2002
Awardee: Data Computer Corporation of America
Funding: $199,993

Description: These funds support the 1999 Standard Medicaid Research File (SMRF) construction and the development of supplemental reports through "Data Marts" in the CMS Data Warehouse structure. These will involve EPSDT, SCHIP and Drug Rebate reporting systems.

Status: This represents only partial funding for a project that is already underway.

01-273 Conversion of Medicaid Statistical Information System to a DB2 Database

Project Officer: Al Celentano
Period: September 2001–September 2002
Awardee: IBM
Funding: $2,699,710

01-276 Descriptive Statistical Data on Health Maintenance Organizations

Project Officer: Katharine Levit
Period: July 2001–September 2002
Awardee: InterStudy Publications
Funding: $16,805

Description: This is a license to use a series of databases:

- The Competitive Edge-HMO Database,
- National HMO Financial Database, and
- MED/OPS Database.

01-278 Time Series Data on Nonprescription Drugs

Project Officer: Katharine Levit
Period: March 2001–September 2002
Awardee: Kline & Company
Funding: $2,500

Description: This project collects manufacturer and retail sales data of over-the-counter drugs and sundries. These data are used in the development of expenditure estimates for the National Health Accounts.

Status: These data are purchased at regular intervals.

99-147 Meeting Support Arrangements

Project Officer: Sydney Galloway
Period: September 1999–September 2002
Awardee: AFYA
Funding: $119,404

Description: This project provides meeting support for CMS or ORDI meetings that involve participants and/or observers from the public or private sector. The immediate concern will be the usability and arrangement of web-based information on the CMS research program and on the statistics about CMS programs.

99-073 Assessing the Impact of a Comprehensive School-Based Health, Educational, and Social Services Program for Pregnant Adolescents on Their Pregnancy Outcomes and the Health of Their Children

Project Officer: Richard Bragg
Period: September 1999–June 2002
Awardee: Morgan State University
Funding: $249,287

Description: This project will assess the impact of the Laurence G. Paquin Middle/High School, a school-based comprehensive program in health, education, and social services, by comparing the students in the Paquin Program with pregnant teens in other parts of the Baltimore City educational system. It will seek to undertake a comprehensive evaluation of the Paquin School Program in order to assess its impact on the pregnancy outcomes of the pregnant adolescents and on the health of their children. The goal of the proposed project is to assess the impact of an existing school-based comprehensive program in health, educational, and social services for pregnant and/or parenting adolescents on the pregnancy outcomes and health and nutritional status of their infants and children. The project will test several hypotheses with respect to the impact of the Paquin School Program on the adolescents' pregnancy outcomes.

Status: This project, which was awarded under CMS' grant program for Historically Black Colleges and Universities (HBCU) Health Services Research Grant, is in progress.

99-074 Medicaid Managed Care Quality and Costs Among Black and White Adults with Diabetes Mellitus

Project Officer: Richard Bragg
Period: September 1999–February 2002
Awardee: Morehouse, School of Medicine
Funding: $157,609

Description: This project is a retrospective analysis of State Medicaid claims data relating to diabetes mellitus treatment under the managed care program. The goals of this project are to assess the quality of care and the value of a type of Medicaid managed care plan compared to non-managed care. The study provides an in-depth discussion of: 1) the patterns of access of care for diabetes mellitus under managed care; 2) the risk of diabetes-related hospitalizations; 3) the risk of acute complications; and 4) the costs of diabetes care among Black and White adult Medicaid beneficiaries enrolled in the Georgia Better Health Care Practice.

Status: This project, which was awarded under CMS' grant program for Historically Black Colleges and Universities Health Services Research, is continuing.

00-075 Efficacy of a Culturally Sensitive Health Promotion Program To Improve Exercise and Dietary Behaviors in African American Elders with Hypertension

Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: Southern University and A&M College, School of Nursing
Funding: $205,142

Description: The project is to test the efficacy of a culturally sensitive health promotion program that seeks to improve exercise and diet, two behaviors important in controlling hypertension in African American elders with hypertension. The project will compare the impact of outcomes of: knowledge, efficacy expectations and outcomes (beliefs about performing exercise and dietary behaviors), and change on exercise and dietary behaviors of elders who participate in one of two versions of a health promotion program. The first year will be conducted in Baton Rouge, Louisiana and the second year in Jackson, Mississippi, under the coordination of the two participating universities. The intervention will be conducted at public housing complexes and involve resident coordinators who would serve as liaisons between participants and researchers.

Status: Data are collected at baseline and remeasured at 3 and 6 months on nine variables. This project, which was awarded under CMS' grant program for Historically Black Colleges and Universities, is in progress.

00-072 Health Promotion in the African American Community: A Computer-Based Nutrition Program

Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: Prairie View A&M University
Funding: $231,008

Description: The purpose of the study is to investigate the effectiveness of a computer-based nutrition education program by African American adults in community settings as compared to traditional methods of instruction. A research team of faculty and nursing students will implement project activities (based on health promotion behaviors) using an interactive multimedia computer program to teach nutrition to African American adults. The investigators will validate the feasibility of computer-based intervention strategies and materials designed to teach African American adults about nutrition in a community setting when compared to traditional methods of instruction. The project goals are: 1) to form collaborative partnerships within minority communities in need of health promotion focusing on nutrition, 2) to examine the difference in outcomes of health education using a computer based delivery method when compared to traditional methods, and 3) to determine the feasibility of using a computer-based education program to teach health promotion to African American adults in urban community settings.

Status: This project, which was awarded under HCFA's grant program for Historically Black Colleges and Universities, is in progress.

00-073 Increasing Breast Cancer Screening in African American Women: A Community Pilot Project

Project Officer: Richard Bragg
Period: September 2001–September 2002
Awardee: Meharry Medical College
Funding: $249,980

Description: The study seeks to determine the extent to which breast cancer screening can be increased and breast cancer can be prevented among low income and elderly African-American women using a combination of culturally appropriate strategic approaches that are implemented through a coordinated community effort. The main goal is to develop, implement, and evaluate a culturally-sensitive, multi-faceted pilot program that seeks to improve breast cancer screening knowledge, attitudes, and practices in a high risk population of poor and elderly African American women.

This 2-year demonstration is a collaborative venture between Meharry's Cancer Control Research Unit, the East Nashville Family Health Care Group, the Community Coalition for Minority Health, the Middle Tennessee Breast and Cervical Cancer Screening Coalition, and other selected organizations and individuals in the East Nashville Community of Tennessee.

Status: This project was awarded under CMS' grant program for Historically Black Colleges and Universities. The research project is in its second year.

00-074 Reducing Hospitalization and Rehabilitation Medicaid Costs in African American Teens with Spinal Cord Injuries Who Survive Teen Violence

Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: Southern University and A&M College
Funding: $250,000

Description: The main goal of this demonstration is to study the major contributions to the Medicaid cost for re-hospitalization and rehabilitation associated with spinal cord injury (SCI) of African American survivors of teen violence. The specific objectives of the project are to: 1) identify Medicaid costs for the first year following the injury and subsequent 5 years, 2) collect data regarding the current state of followup care, 3) reduce preventable hospitalization costs by the improved access to quality care and comprehensive followup of SCI, 4) use the findings of the study to develop a case management model for reducing Medicaid costs in this population, and 5) conduct intervention activities to reach out to teens in the Teen Outreach Program to help prevent violence and injury. The 2-year intervention study uses a quasi-experimental pre-test and post-test design with a convenience sample of 60 teens in Louisiana. Teens will be exposed to a multi-component intervention treatment, and compared with a control group of similar matched cases of teens with SCI from Maryland.

Status: This project was awarded under CMS' grant program for Historically Black Colleges and Universities. The project is in its second year.

01-245 Increasing Mammography Screening Among African American Females in Rural Areas: An Educational Intervention Program

Project Officer: Richard Bragg
Period: September 2001–September 2003
Awardee: Tuskegee University
Funding: $120,282

Description: The goal of the project is to increase mammography screening among African-American females. The objectives are to 1) evaluate the effectiveness of breast cancer screening education program on mammography rates among African-American females age 40 and over living in rural communities, 2) increase breast self-examination and mammography rates among African-American females age 40 and over living in rural areas of Alabama, 3) evaluate whether the project has more or less of an impact among women who have a family history of breast cancer, and 4) compare the results of a rural education intervention project with the same project previously delivered in an urban setting. The project is being implemented in two counties in the Tuskegee, Alabama area; Macon and Greene. The population of these counties is predominantly African-American, 86 percent and 81 percent respectively. The educational level is low, with approximately 50 percent having earned a high school diploma. In addition, the only hospital is the Veterans Medical Center and residents must travel up to 30 miles to receive secondary care. Poverty levels are high, there is a significant vulnerable population and many residents are uninsured and receiving public assistance.

Status: Collaborations have been formed with the Ministerial Alliance of Black Churches which will host the project, the Office of Minority Health in the Alabama State Department of Health, and the Cancer Prevention Program to provide free mammograms. Tuskegee University National Center for Bioethics and Research in Health Care will provide administrative support and guidance.

01-244 Strategies to Improve Prostate Cancer Screening Rates Among African-American Men in the Baltimore Metro Area

Project Officer: Richard Bragg
Period: September 2001–September 2003
Awardee: Morgan State University
Funding: $121,765

Description: The overall goal of the project is to increase the number of African-American men, forty (40) years and older, who participate in routine screening for prostate cancer each year. The objectives are 1) to determine through focus groups, barriers and enablers to routing screening for prostate cancer among African-American men in the Baltimore Metro Area, 2) to increase the knowledge of African-American men about prostate health and prostate cancer, through a health education program, as measured by a pre and post-test and 3) to change the behavior of African-American men relative to routine screening for prostate

cancer, by increasing the number who participate in regular screening. The project will be conducted in two phases in three counties in the Baltimore metropolitan area. In Phase I qualitative data will be collected on barriers and enablers to prostate cancer screening from participants in ten focus groups conducted in three targeted counties. In Phase II the planning and implementation of an education intervention program will utilize the "train-the-trainer" model.

Status: The pre/post test survey has been completed.

01-243 Diabetes: Factors Influencing Self-Care Among African Americans in Rural and Urban Populations

Project Officer: Richard Bragg
Period: September 2001–September 2003
Awardee: University of the District of Columbia
Funding: $124,320

Description: The purpose of this project is to identify, assess, and evaluate knowledge about diabetes prevention, self care (compliance), and locus of control behaviors among a population of urban and rural African Americans 45 years and older living in Baltimore, MD, the District of Columbia, and Petersburg, VA. Individuals will be recruited from free clinics, practitioners, senior citizens centers, and faith based organizations. The multi-phase project will identify at-risk diabetics (diabetics with self-care deficits) and initiate specific sensitive interventions to decrease risk factors associated with diabetes complications and to improve self-care. The aim of the project is to identify high-risk type-2 diabetics, develop intervention strategies that are culturally sensitive, and provide an educational curriculum (regarding diabetes and self-care behavior) that recognized the impact of culture in disease management. These interventions will target three areas: health promotion, outreach, and diabetes care.

Status: Four historically black colleges and universities collaborate on this project: The University of the District of Columbia, Morgan State University, Coppin State College and Virginia State University.

01-251 Grants Writing Workshop for Historically Black Colleges and Universities' Researchers - II

Project Officer: Richard Bragg
Period: June 2001–January 2002
Awardee: Tennessee State University
Funding: $25,000

Description: This small project is designed to increase the number of well-trained competitive minority researchers. The specific objectives of this workshop are to: 1) train Historically Black Colleges and Universities (HBCU) researchers to develop fundable research proposals relative to understanding and improving certain aspects of minority health status, 2) develop an HBCU network of cross-institutional collaborators in health services research, 3) explore methods of increasing minority participation in research populations, 4) examine successful grants that have been written to learn more about the mechanics of writing a fundable grant proposal, and 5) enhance the capacity of HBCU researchers to work with CMS.

Status: The workshop is being planned.

01-255 HBCU's Health Services Research Network Strategic Planning Workshop - Improving Health Outcomes and Minimizing Health Disparities in the African American Population

Project Officer: Richard Bragg
Period: July 2001–March 2002
Awardee: Bowie State University, Department of Nursing, Center for Learning and Technology
Funding: $25,000

Description: This workshop is to address the nature and scope of the HBCU Health Services Network as it relates to the existing health disparities in the African American communities. It will discuss current knowledge, strategies to address health disparities, and

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gaps in the knowledge; clarify the role of the HBCU Network; identify research needs; and make recommendations to improve the health outcomes of African Americans.

Status: The workshop was held in December 2001. The final report is in preparation.

99-075 Transcultural Case Management (TCM) Integrated HIV Health Care and Support Services

Project Officer: Richard Bragg
Period: September 1999–March 2002
Awardee: University of Texas Health Science Center at Houston
Funding: $228,248

Description: The project is implementing a Transcultural Case Management (TCM) model that will increase access, utilization of services, and better the quality of care for human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) clients of Hispanic descent who live in the U.S.-Mexico border region. The TCM will create a network of services and referral relationships among private and public agencies collaborating on this project. The ultimate aim is to decrease the costs of these patients by decreasing hospital days and improve satisfaction with care through the use of community health workers. The transcultural approach to health care proposes to deliver holistic care within a framework of attention and respect to differences and similarities in cultural values, beliefs, and lifestyles among different border populations. Its goal is to contribute to a patient's health and well being by providing culturally congruent, competent, and compassionate care.

Status: This project, which was awarded under CMS' grant program for Hispanic Health Services Research Grant, is continuing.

99-072 Cervical and Breast Cancer Screening for Post-Reproductive Age Hispanic Women Residing Near the U.S.-Mexico Border

Project Officer: Richard Bragg
Period: September 1999–May 2002
Awardee: University of Arizona, Arizona Board of Regents
Funding: $263,281

Description: The study, which focuses on the border community of Douglass/Sulphur Springs Valley in Arizona, highlights the immense and unique health problems that plague the U.S.-Mexico border region. The U.S.-Mexico border area in general and the Arizona (U.S.)-Sonora (Mexico) border area in particular has had a history of economic ties and the sharing of physical, economic ties, cultural, and health characteristics. Some of the main contributing factors associated with the myriad of health problems in the region include: poverty, unavailability, and accessibility of preventive health and treatment services. Of particular interest to the researchers is the preventive value of screening for cervical and breast cancers associated with Hispanic women who live in a border community (Douglass) on the U.S.-Mexico border. This study will allow the researcher to address these problems by using a 2-year community-based cohort intervention study, and gather information relating to utilization and barriers to utilization of breast and cervical cancer screening services.

Status: This project, which was awarded under CMS' grant program for Hispanic Health Services Research, is continuing.

99-078 Hispanic Health Services Utilization: Defining and Exploring Disparities

Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: Massachusetts General Hospital
Funding: $194,968

Description: The study will use the 1996 HealthCare Cost and Utilization Project State Inpatient Database (merged with the American Hospital Association Annual Survey of Hospitals) and Census data to examine the differences in utilization of diagnostic and therapeutic health services between Hispanics and Whites in three States, California, New York, Florida. The purpose of this project is: 1) to quantitatively define diagnostic and therapeutic health service utilization for Hispanics versus non-Hispanic Whites along a set of five specific clinical conditions (cardiovascular disease, cerebrovascular disease, epilepsy, peptic ulcer disease/gastritis, and benign gynecologic conditions); and 2) to qualitatively explore a variety of hypotheses as to why disparities in diagnostic and therapeutic health services exist (barriers to doctor-patient communication, patient perception of the role of the physician, sociocultural variations in presentation of symptoms and patient preferences, and physician bias).

Status: This project, which was awarded under the CMS' grant program for Hispanic Health Services Research, is in progress. It was originally awarded to Weill Medical College of Cornel University, but, with the relocation of the Principal Investigator, was moved to Mass General in May 2002.

00-078 A Systematic Approach to Improving Pap Smear Screening Rates Among Hispanic/Latina Women in Managed Medicaid Systems

Project Officer:	Richard Bragg
Period:	September 2000–September 2002
Awardee:	California State University, Fresno Foundation, College of Health and Human Services, Grants and Research
Funding:	$218,646

Description: One major reason for high rates of cervical cancer in Hispanic/Latino women is the under-utilization of pap smear screening. This project identifies barriers to pap smear screening facing Hispanic/Latina women within a Medicaid managed care system. Specifically, the goals of this project are to: 1) identify the alterable barriers to Pap smear screening facing Latina women, 2) measure the proportion of Latina women who are screened for cervical cancer; and 3) design a comprehensive community-based outreach and health education intervention strategy to improve the cervical cancer screening rates among the Latina population. Participants are from four large community health centers (urban vs rural) that serve predominately Hispanics in the Central Valley and the Blue Cross Managed MediCaid system.

Status: This project was awarded under CMS' grant program for Hispanic Health Services Research. The project is in its second year.

01-247 Understanding the Role of Culture in the Access and Utilization of Telemedicine Health Services Among Hispanic, Native Americans, and White non-Hispanic Populations

Project Officer:	Richard Bragg
Period:	September 2000–September 2003
Awardee:	University of Arizona, Cancer Center
Funding:	$249,283

Description: The objectives of the study are to: 1) identify if telemedicine increases or decreases the number of clinic encounters between patient and clinician at the same rate for Mexican American, Navajo, and non-Hispanic White populations, 2) examine if telemedicine alters the type or complexity of the clinical encounter at the same level for these populations, 3) assess if telemedicine affects the cost of providing clinical services for the management of chronic and/or rehabilitative conditions at the same amount for these populations, 4) examine if telemedicine affects patient compliance (e.g., taking medications as prescribed, doing exercise as instructed, etc.) at the same level for these populations, 5) assess if minority patients perceive that cultural competency is an important factor in the delivery of telemedicine services such that it may impact utilization of these services, and 6) examine how telemedicine impacts the quality of life for these populations.

Status: The project was awarded under CMS's Hispanic Health Services Research Grant Program. The research project is in its second year.

00-076 Intergenerational HIV Prevention Intervention for Latina Women

Project Officer: Richard Bragg
Period: September 2000–September 2002
Awardee: University of California at San Francisco
Funding: $250,075

Description: This project seeks to develop an intergenerational human immunodeficiency virus (HIV) prevention intervention that addresses barriers to access of HIV services, and that provides a benchmark for the level of quality that Latina HIV prevention services can achieve. The project brings together Latino researchers and community providers to design, pilot, and evaluate a community based, culturally-targeted HIV prevention intervention for Latina women. It is a combination of 1) a series of qualitative data collection from interviews with focus groups, 2) the development of HIV prevention intervention curriculum, and 3) pilot testing HIV prevention intervention curriculum with Latinas in the San Francisco metropolitan area. The focus groups and individual interviews with Latina women aged 18 to 45 years old will serve to assess perceptions of HIV risk and barriers to prevention of HIV, and to evaluate the process, the generalizability and initial impact of the intervention across health delivery systems.

Status: This project was awarded under CMS' grant program for Hispanic Health Services Research. The project is in its second year.

00-079 Identification of Risk Factors, Barriers, and Severity for Emergency Room Asthma in Puerto Rico

Project Officer: Richard Bragg
Period: September 2000–March 2003
Awardee: Ponce School of Medicine
Funding: $250,075

Description: The goal of this project is to improve intervention strategies and treatment outcomes for severe asthmatics in Puerto Rico. The project will define the prevalence of moderate and severe asthma, study the demographic characteristics, investigate the seasonal trends of Emergency Room (ER) use, study the quality of life, and identify potential educational and intervention programs. The study will include chart review to determine whether the patient had an actual diagnosis of asthma, prescribed treatment, age, sex, peak flow, asthma history, duration of attack, treatment with beta-antagonist nebulizers or steroids, referrals, and follow up appointment.

Status: This project was awarded under CMS's grant program for Hispanic Health Services Research. The project is in its second year.

01-147 The Effectiveness of Insuring Uninsured Latino Children Using Community-Based Case-Managers: A Randomized Trial

Project Officer: Richard Bragg
Period: September 2001–September 2003
Awardee: Boston Medical Center Corporation
Funding: $125,000

Description: The specific aim of this research is to conduct a randomized trial to evaluate whether community-based case managers are more effective than traditional methods in insuring uninsured children. Based on this aim, the project will examine or test four hypotheses: 1) A significantly higher proportion of uninsured children randomized to a community-based case manager will obtain health insurance. 2) The mean duration of time in obtaining health insurance coverage will be significantly shorter for uninsured children with a community-based case manager compared with those obtaining insurance through traditional methods. 3) A significantly greater proportion of uninsured children who obtain health insurance through community-based case managers will continuously be insured over a 1-year period compared with uninsured children who obtain insurance through traditional methods. 4) Parental satisfaction (or patient satisfaction, in the case of adolescents living in shelters/group homes) with the

process of obtaining health insurance will be significantly higher among uninsured children randomized to community-based case managers compared with those randomized to traditional methods of obtaining insurance.

Status: This newly initiated project is in the startup phase.

01-146 Medication Analysis in Mexican American Aged

Project Officer:	Richard Bragg
Period:	September 2001–September 2003
Awardee:	University of Texas Health Science Center at San Antonio
Funding:	$110,000

Description: The project's primary aim is to understand the extent of suboptimal medication use in elderly Mexican Americans. The objectives are to: 1) Estimate baseline prevalence and 2 year incidence of suboptimal prescription use. 2) Identify baseline characteristics of subjects who report suboptimal prescribed medication use. 3) Assess the association between suboptimal medication use and morbidity and mortality 2 and 4 years after the baseline survey. 4) Assess the association between suboptimal prescription drug use and use of health services 2 and 4 years after the baseline survey.

Status: This is a newly initiated project.

01-149 Studying Migrant and Seasonal Farm Workers

Project Officer:	Richard Bragg
Period:	September 2001–September 2003
Awardee:	Michigan State University
Funding:	$123,200

Description: This two year cross-sectional pilot study among migrant and seasonal farm workers will provide data and information on socio-demographics, housing conditions, work conditions, self-reported and doctor-reported health conditions, health services needs, and utilization. This research study will utilize a need assessment strategy (500 subjects) to: 1) Produce a comprehensive profile of the medical health needs of migrant and seasonal farm workers in Northern Michigan. 2) Identify the types of services required and general practice among migrant and seasonal farm workers in Northern Michigan. 3) Determine the association between the health needs of farm workers, types of services required, and health services utilization rates in the population.

Status: This newly initiated project is in the startup phase.

01-252 Grants Writing Workshop for Hispanic Researchers - II

Project Officer:	Richard Bragg
Period:	July 2001–May 2002
Awardee:	Stanford University, School of Medicine, Hispanic Center for Excellence
Funding:	$25,000

Description: The purpose of this project is to increase the capacity of Hispanic faculty, fellows, and scholars conducting health care services research. This is a 2-day workshop aimed at training Hispanic faculty, fellows, and scholars on how to successfully write health services research grants. The project objectives are to increase the number of Hispanic researchers applying for and receiving health services research grants, and to increase the number of grants on Hispanic health services topics.

Status: The workshop is being planned.

01-256 Health Disparities in the Hispanic American Community: Analysis, Recommendations, and Strategies

Project Officer:	Richard Bragg
Period:	June 2001–January 2002
Awardee:	Massachusetts General Hospital - Harvard Medical School - Institute for Health Policy
Funding:	$25,000

Description: This project develops a plan to address health disparities in the Hispanic American communities. Recommendations and strategies for shaping a future research agenda regarding health disparities in this population will be a product of this work.

01-271 Hispanic Technical Assistance Workshop on Accessing, Utilizing, and Understanding HCFA's Medicare/Medicaid Data for Hispanic American Health Professionals/Researchers - Mid Atlantic Region"

Project Officer:	Richard Bragg
Period:	July 2001–March 2002
Awardee:	Howard University, College of Medicine
Funding:	$25,000

Description: This project will 1) increase the number of under-represented Hispanic American investigators with the basic skills needed to begin collaborating in or conducting minority research that uses CMS data sets; 2) orient these researchers to CMS' data sets; 3) provide for their education in the acquisition of such data and in their content, file layouts and data field definitions; 4) provide hands-on experience with such data; 5) increase the technical skills and; 6) encourage cross-institutional collaboration.

00-008 Impact of Managed Care upon Medicaid Women and Newborns

Project Officer:	Spike Duzor
Period:	January 2000–May 2002
Awardee:	University of Rochester, School of Medicine, Department of Community and Preventive Medicine
Funding:	$24,048

Description: The overall objective of this project was to examine the influence of a managed care program upon the processes and outcomes of care related to delivery for mothers and newborns covered by Medicaid. The amount and type of care received, and outcomes experienced by women and their newborns, was compared between those enrolled in Medicaid managed care (MMC) and those in traditional fee-for-service Medicaid (FFSM) plans. In addition, trends over time and characteristics of MMC enrollees were examined. Information regarding socioeconomic and demographic characteristics, processes of care related to delivery and birth outcomes, were collected for the years 1992-1997. Two primary sources of data were used: a perinatal database (created from electronic birth certificates), and the New York State Medicaid administrative claims and enrollment files.

Status: The grant period expired and a dissertation was not received.

01-043 How Do Variations in Treatment of Ductal Carcinoma In Situ (DCIS) Affect Outcomes

Project Officer:	Spike Duzor
Period:	February 2001–May 2002
Awardee:	University of Rochester, School of Medicine
Funding:	$31,267

Description: This project examines the effects of geographic and temporal variation in the treatment and evaluation of women diagnosed with Ductal Carcinoma In Situ (DCIS). It tests three major hypotheses:

- there is statistically significant geographic and temporal variation in the treatment of women with ductal carcinoma in situ, both in type of surgery (mastectomy or breast-conserving surgery) and use of radiotherapy;
- practice patterns vary by region in the inappropriate use of radiologic tests to find metastatic disease in women diagnosed with DCIS, (which is not metastatic); and
- variation in treatment of DCIS has consequences for rates of recurrence to DCIS and invasive breast cancer. The study measures the geographic variation and the impact region effects have on patient outcomes for women age 65 and older.

Status: Dissertation grants do not require progress reports. The student has submitted the dissertation as the "final report."

01-044 Prescription-Filling Problems in the Medicare Population

Project Officer: Spike Duzor
Period: February 2001–June 2002
Awardee: University of Maryland, Baltimore County
Funding: $25,802

Description: The project examines why some Medicare beneficiaries have problems filling their prescriptions while others do not. There are three study aims: 1) The examination of people who report problems, the medications that they do not fill and the reasons for not filling; 2) the comparison of people with prescription-filling problems to those without such problems on socioeconomic variables; and 3) the comparison of prescriptions not filled to those filled by drug class and medical necessity. The work uses a behavioral model that describes access to medical care as a function of predisposing, enabling and need factors. It is hypothesized that prescription-filling problems decrease with greater levels of medical need, increase with diminished enabling resources and decrease with a predisposition toward accessing health care services. The project will use the Access to Care and Cost and Use files of the Medicare Current Beneficiary Survey (1996-1998).

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

01-045 Effect of Payment Methods on Rehabilitation Care in Nursing Homes

Project Officer: Spike Duzor
Period: February 2001–February 2002
Awardee: University of Michigan, School of Public Health
Funding: $25,238

Description: The study will assess the effect of payment methods on the delivery of ancillary rehabilitation therapy to nursing home residents. Three payment methods for nursing homes are retrospective cost-based, prospective flat rate, and case-mix. Each has a difference economic incentive for providers to deliver care. Many residents require specialized rehabilitation therapy. Both access to rehabilitation and the intensity of rehabilitation care are proposed as dependent variables. Multivariate regression analyses are proposed to control for resident-level need, facility characteristics, and nursing home market conditions.

Status: The dissertation has been received.

01-046 Long-Term Job Lock Revisited: Estimating the Effect of Federal Health Insurance Portability Legislation on Job Transitions for Sick Individuals, 1996-1999

Project Officer: Spike Duzor
Period: February 2001–February 2002
Awardee: University of California at Berkeley
Funding: $32,400

Description: This project measures the direct impact of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on job mobility. The purpose of HIPAA was to increase job mobility of sick individuals by reducing job lock associated with pre-existing conditions periods, thereby significantly reducing the ability of insurers to impose such restrictions. The project has an asymmetric information screening model that predicts HIPAA should increase opportunities for sick individuals relative to health individuals and full information labor supply/demand model that predicts the opposite result. It uses March Current Population Survey data from 1996-1999 to exploit HIPAA as a Federal quasi-experiment via difference-in-difference-in-differences to determine whether the evidence is consistent with either model.

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

01-047 HealthChoice: The Impact of Mandated Managed Care on Emergency Department Utilization in the State of Maryland

Project Officer: Spike Duzor
Period: February 2001–February 2002
Awardee: University of Maryland, Baltimore County
Funding: $32,400

Description: This study evaluates Maryland Medicaid beneficiaries' access into managed care organizations pre- and post-implementation of HealthChoice, a capitated managed care program operating under a 1115 demonstration waiver. The study will determine the effect of HealthChoice on the likelihood of using specific health services; emergency department and primary care visits. Emergency department visits for ambulatory care sensitive conditions serve as indicators that access problems or deficiencies in ambulatory outpatient management may be occurring, while primary care visits for ambulatory care sensitive conditions serve as indicators that access to managed care plans is occurring. Four years of Maryland Medicaid claims and encounter data are used. Logistic regression analysis on the population is used to determine the effect of HealthChoice, and other sociodemographic and health care delivery system variables on the likelihood of using emergency and primary care health services.

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

01-048 Incontinence Morbidity, Adjustment to Illness, and Quality of Life after Prostatectomy

Project Officer: Spike Duzor
Period: February 2001–February 2002
Awardee: University of Maryland, Baltimore County
Funding: $31,962

Description: The study examines the influence of urinary incontinence on adjustment to illness and quality of life in men one year after prostatectomy. A cross-sectional survey design with 156 subjects will be used to answer three questions: 1) What portion of the variance in psychosocial adjustment to illness is explained by urologic morbidity when controlling for the type of surgery, race, practice of Kegala exercise, and comorbidities in incontinent men post prostatectomy 2) How much of the variance in quality of life is explained by urologic morbidity? 3) Is there a significant difference in quality of life in middle aged and elder men in the 12-18 months after surgery? Multivariate analysis techniques including hierarchical multiple regression and factorial analysis of variance will be used on these data.

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

01-049 Effects of Health Care Provider Affiliations on Patient Treatment and Outcomes

Project Officer: Carl Hackerman
Period: February 2001–February 2002
Awardee: Stanford University
Funding: $24,772

Description: This project studies the natures and effects of two types of provider alliances: multi-hospital systems and hospital-physician affiliations. It assesses the impact of multi-hospital systems on the nature of care provided and ultimately on patient outcomes. The available data on multi-hospital systems will be improved by placing systems into meaningful categories. Regression analysis is used to determine the effects of systems membership on the treatment, costs, and mortality of Medicare patients, as well as on the use–treatment technologies. Lastly, it will determine whether system effects vary by system type. In the area of hospital-physician affiliations, the project will examine the characteristics associated with the growth and evolution of various types of affiliations. Using the American Hospital Association and Medicare data, an analysis will be done on whether these affiliations have had an impact on the types of treatment provided, the costs of treatment to Medicare (inpatient, outpatient and physician), and mortality.

Status: The dissertation has been completed and received by CMS.

01-050 **Determinants of Influenza Vaccination Timing**

Project Officer: Spike Duzor
Period: February 2001–February 2002
Awardee: Johns Hopkins University
Funding: $31,807

Description: This study uses both cross-sectional and survival analyses to examine three aims among the US elderly population: 1) Determine whether the receipt and timing of influenza vaccination affect the individual risk of hospitalization rate due to influenza and its complications during the same influenza season. 2) Assess how the risks of influenza affect influenza vaccination timing. These risks are exemplified by (a) a chronic disease which will increase the risk of influenza and its complications and (b) influenza epidemic activity level. 3) Explore whether there is a difference in influenza vaccination timing between those receiving other medical care, a proxy for a lower time cost for vaccination, in addition to influenza vaccination and those who do not.

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

01-051 **Risk Factors Unique to Early Onset Pneumonias**

Project Officer: Spike Duzor
Period: February 2001–April 2002
Awardee: San Diego State University Foundation, College of Health and Human Services
Funding: $31,666

Description: This study will seek to determine those risk factors that are unique to early onset pneumonias (EOP). This is a matched case control study with a 1:3 case to control ratio in which cases, patients with EOP, are compared to controls with late onset pneumonias (LOP). Variables of interest include patient characteristics, injury characteristics, and care experiences after admission. Univariable analysis will employ Mantel-Haenszel calculations for matched samples for categorical variables and conditional logistic regression for continuous variables. Multivariable analysis will be made with conditional logistic regression modeling.

Status: Dissertation grants do not require progress reports. The student is working on the project and is expected to submit the dissertation as the "final report."

02-023 **A Longitudinal Study of Health Coverage Transitions Between the Years of 59 and 67; The Risk of Being Uninsured and Underinsured**

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: Syracuse University
Funding: $26,055

Description: This longitudinal study will look at the risk of being uninsured or lacking sufficient coverage between the years of 59 and 67. Using the Health and Retirement Survey, the analysis will include descriptive models of the health insurance coverage of people aged 59 to 67 years, regression models of the determinants of health insurance coverage over the six year period, and hazard models of the risk of losing coverage before Medicare eligibility and not having sufficient coverage after Medicare eligibility. The project will focus on the insurance coverage of subgroups, such as women and minorities, and on insurance coverage changes after certain life events, like early retirement, losing a spouse, or Medicare eligibility.

Status: A copy of the dissertation is expected in 2003.

02-024 Effects of State Medicaid Policies on Elderly Persons' Savings Patterns and Long Term Care

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: University of North Carolina at Chapel Hill, Office of Research Services, for Department of Health Policy and Administration
Funding: $20,659

Description: The objective of this study is to investigate the influence of health and variations in State Medicaid policies on the savings patterns and long-term care (LTC) decisions of elderly persons who anticipate the need for LTC. This study will use a dynamic, stochastic model to examine the effect of variations in these rules across States on the decumulation or accumulation of savings and on the LTC decisions of the elderly. Specific questions are: 1) What is the extent to which the elderly must impoverish themselves in order to obtain Medicaid eligibility; 2) are the middle class elderly transferring, sheltering, or under-reporting assets in order to qualify for Medicaid coverage or are they accumulating wealth to avoid the need for Medicaid coverage because of welfare aversion; 3) what are the effects of Medicaid on the probability of entering a nursing home and on the amounts of formal and informal care provided to elderly persons in the community; and 4) what is the price sensitivity of the demand for formal care and the demand for institutional care other respective price of care.

Status: A copy of the dissertation is expected in 2003.

02-025 Medicare Health Maintenance Organizations Withdrawals and Modifications

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: University of Minnesota, School of Public Health
Funding: $32,400

Description: The objective of the proposed research study is to model the decision processes of health maintenance organizations (HMOs) that offer Medicare+Choice (M+C) plans and to identify the factors associated with the HMO's decisions regarding their M+C plans for the following contract year. Specifically, the purpose of this study is to identify the factors associated with the following HMO decisions: 1) whether or not to renew the M+C contract in a geographic area; 2) whether or not to reduce the number of counties defined by the M+C contract; 3) whether or not to change the level of supplemental benefits, change the premium, or both; and 4) whether or not to change the configuration of M+C plans offered. HMO decisions will be modeled for 1999-2000 and 2000-2001. The analysis will use secondary data from CMS, Interstudy, the Area Resource File, and from the Bureau of Labor Statistics. The study design is a 2 stage analysis, and the unit of analysis is a county.

Status: A copy of the dissertation is expected in 2003.

02-026 Using Risk Sharing and Risk Adjustment Strategies for Dealing with the Tradeoff Between Selection and Efficiency

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: Boston University, Graduate School of Arts and Sciences, Department of Economics
Funding: $30,055

Description: This study will develop a model of optimal payment policy to health plans in which regulators choose risk adjustment, risk sharing, and outlier threshold parameters in order to optimize an objective function which reflects a tradeoff between efficiency and access measures. Data from the Medicare 5 percent Standard Analytical File (SAF, 1996-1997) will be used to empirically evaluate the effectiveness of these risk-adjustment and risk-sharing strategies, and compare the results with other empirical studies. The Medicare Current Beneficiary Survey (MCBS, 1996-1999) will be used to empirically

examine the relationship between cost information and taste variables. The goal is to better understand the factors driving health plan choice, especially the correlation between taste variables and cost variables drive selection, and whether there are any changes over time. The study will also explore whether Medicare+Choice (M+C) health maintenance organizations (HMOs) deferentially select aged versus disabled enrollees in response to payment incentives. Analysis will use county-level data available from CMS and the Area Resource File.

Status: A copy of the dissertation is expected in 2003.

0-027 Relationships Between Nursing Staff and Resident Quality of Care and Quality of Life

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: University of Minnesota, School of Public Health
Funding: $32,400

Description: This study investigates how nurse staffing affects quality of life (QOL) and quality of care (QOC) for nursing home residents. The independent variables are: 1) nursing staff to resident ratios; 2) turnover/stability rates; and 3) extent of nursing pool use (as opposed to payroll). The staff ratios are calculated separately for registered nurses, licensed practical nurses, and certified nursing assistants (CNA). Turnover and pool use are calculated separately for licensed personnel and CNAs. Facility level control variables are ownership, percentage of Medicaid residents, stability of administrator tenure, and (for QOL) activity personnel to resident ratios. QOL is defined as 9 selected quality indicators, (for example, bedsores, falls, and urinary tract infections), which will be risk adjusted. The study uses four sources of data: 1) a CMS national survey using personal interviews with nursing home residents; 2) Minimum Data Set (MDS) data for the same nursing home residents, one year prior to interview; 3) the On-Line Survey and Certification Assessment Review (OSCAR) nursing home staffing data; and 4) an administrative survey developed specifically for this dissertation.

Status: A copy of the dissertation is expected in 2003.

02-028 Evaluating Health System Performance: Access and Quality of Care for Acute Cardiac Events in the Rural Medicare Population

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: Ohio State University Research Foundation
Funding: $30,240

Description: This descriptive cross sectional study will utilize data from the Medicare Current Beneficiary Survey (MCBS) to examine current practice of treating the rural elderly diagnosed with acute myocardial infarction (AMI). The study will compare the characteristics of those who receive their treatment for AMI at a hospital that performs a high volume of interventional cardiac procedures with those who receive treatment in low volume hospitals. Claims data will be used to construct a chain of events surrounding a critical cardiac diagnosis. STATA for the Provider of Services database will describe the volume of cardiac interventions accomplished at treating hospitals. The Behavioral Model of Healthcare Utilization provides the structure for the study—namely, an examination of present practices to determine the extent to which perceived or evaluated need, rather than predisposing characteristics of enabling resources, determines access to health care services.

Status: A copy of the dissertation is expected in 2003.

02-029 Caregiving from the Care Recipient Perspective: Influence of Caregiving on Health and Use of Health Services

Project Officer: Spike Duzor
Period: February 2002–January 2003
Awardee: Johns Hopkins University
Funding: $31,536

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Description: The goal of this research is to investigate the influence of informal care arrangements on health and health services use among a group of elderly, moderately to severely disabled women. The proposed study will address the following specific aims: 1) to evaluate the association between intensity of assistance, diversity of caregiver resources, and promotion of care recipient independence with perceived adequacy of the care arrangement (at baseline); 2) to identify care arrangement characteristics at baseline that are longitudinally associated with stability or improvement in care recipient task functioning and mental health and lower risk of mortality; and 3) to evaluate the longitudinal impact of baseline care arrangement characteristics on health services utilization outcomes. The study draws upon data from the Women's Health and Aging Study (WHAS), the Women's Health and Aging Caregiving Survey, and administrative data from the Medicare program.

Status: A copy of the dissertation is expected in 2003.

98-259 Tabulating Medicare Current Beneficiary Survey (MCBS) Data by Type of Service and Age Group

Project Officer: Helen Lazenby
Period: April 1998–February 2002
Awardee: CHD Research Associates
Funding: $49,604

Description: This task order explored the Medicare Current Beneficiary Survey Cost and Use files. It tabulated data from the sample files to produce inflated descriptive data by type of service and age group for the institutionalized and non-institutionalized aged population and Medicare's disabled population. This task order also examined the possibility of producing separate service/age group estimates for the Medicare fee-for-service and Medicare managed care enrollees. These data provided the basis for estimates of personal health care spending by age group within the National Health Accounts.

Status: Complete.

99-116 Medicare Current Beneficiary Survey - II

Project Officer: Frank Eppig
Period: September 1999–September 2004
Awardee: Westat Corporation
Funding: $12,925,094

Description: The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to aid CMS' administration, monitoring, and evaluation of the Medicare program. The survey is focused on health care use, cost, and sources of payment. 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.

Status: The MCBS has been in the field continuously since the fall of 1991. It is currently in its 29th round of interviewing. To date, public use data files are available for 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, and 1999.

01-216 Analysis of Medicare Current Beneficiary Survey (MCBS) Data: Phase III

Project Officer: Sherry Terrell
Period: May 2001–May 2003
Awardee: Research Triangle Institute, (NC)
Funding: $217,132

Description: This project evaluates CMS' success in providing information to each Medicare beneficiary about the Medicare program and promoting the beneficiary's informed choice. Information provided covers benefits, beneficiary liability, premiums, supplemental benefits, a list of plans in the service area and comparison of plan options, quality and performance. This task order analyzes Medicare beneficiary baseline knowledge data, which have been most recently collected through the Medicare Current Beneficiary Survey (MCBS). Analysis of the MCBS baseline data supports monitoring, reporting, accountability and evaluation activities necessary to determine whether the new CMS programs are working as intended.

Status: These analyses continue and build on the prior analyses of the CY 1995-1999 MCBS data including Round 23 (knowledge supplement) and Round 24 (beneficiary need supplement) under previous task order 500-95-0061/04.

01-246 Impact of Nonresponse of MCBS Estimates

Project Officer:	Gerald Adler
Period:	September 2001–September 2002
Awardee:	Health Economics Research
Funding:	$220,233

Description: This task is to conduct methodological studies on data from the Medicare Current Beneficiary Survey (MCBS) in order to: 1) inform project management of improvements that may be made in the design of the study, and 2) inform users of data characteristics that may be important to their analyses. The goal of this activity is to make available the highest quality MCBS data and to facilitate the highest quality analyses. All surveys are subject to several forms of nonresponse, defined generally as the failure to obtain complete measurements on the survey sample. These include unit nonresponse, in which a sample member fails to be interviewed, and item nonresponse, in which certain answers are missing in an otherwise completed questionnaire. In addition, in longitudinal surveys, there is the potential for respondents to respond partially, participating in some rounds of the survey and not in others. This project is intended to produce a thorough documentation and analysis of the degree of nonresponse bias experienced by the MCBS, reasons for and demographic correlates of nonresponse, consequences of nonresponse rates for analyses of MCBS data, and ways in which the impact of nonresponse may be reduced or mitigated.

Status: The project is just getting underway.

01-145 Research and Demonstrations Projects Searchable Database: Stage Two, Improvement, Enhancements, and Implementation

Project Officer:	Linda Lebovic
Period:	September 2001–November 2002
Awardee:	IQ Solutions, Inc.
Funding:	$128,816

Description: This task order takes the work of a previous task, "Health Care Financing Research and Demonstration Projects Searchable Internet Database" through the next logical steps. These involve a careful beta test of the revised database, revision as dictated by this test, retesting, and secondary revision, preparation for access by an audience beyond the ORDI, and the addition of documents and references as appropriate. The ORDI has developed a database of research and demonstration projects, both intramural and extramural. In the previous task the revision of this database from a single file into a relational database was begun. This first task carried the work into the initial testing of the revised database with ORDI staff. The object is to make the information available to individuals who are not familiar with the manipulation of a database held in Microsoft Access, which is the standard software for the Centers for Medicare & Medicaid Services (CMS, formerly known as HCFA). In this process it became apparent that it would be necessary to carry the testing through several stages or waves before the ultimate objective of public access is obtained. One of the missing elements that was found is the absence of electronic access to abstracts of or full copies of reports and articles that come from or relate to individual projects. Much of this is due to the absence of electronic versions. Thus, this task will take us through the second wave/test, a "beta" test, and make available some, but not all, of the related reports/articles in electronic format.

Status: The first version of the revised database structure was completed in mid-November and supplied to staff most involved with the maintenance of the core/fixed information for testing. The second

version was developed based on comments from use of the initial/first version and was displayed to a larger group of ORDI staff in late December. This second version was placed on a shared drive in the ORDI server so staff from throughout ORDI could use it and comment on needed changes. In early January 2002 the effort will be shifted to use of the database to produce the first draft of the "Active Projects Report, 2002."

00-171 Support for Research and Analytic Activities - IQ Solutions, Inc.

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: IQ Solutions, Inc.
Funding: $0

Description: This project provides support for CMS' research and analytic program. Specifically, it will support project design and operation, dissemination and distribution of results, and data related activities. The base award was for 1 year with a maximum of 4 option years.

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO#1) Support for Research and Analytic Activities; (TO#2) Active Projects Report: Reconsideration, Revision, and Production Improvements; (TO#3) Research and Demonstration Projects Searchable Database; Stage Two Improvement, Enhancements, and Implementation. Individual tasks are described separately.

00-172 Support for Research and Analytic Activities - ANASYS

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: ANASYS
Funding: $0

Description: This project provides research and analytic resources with special focus on the automated data processing (ADP) area. The contract is to supply design, development, and implementation resources with emphasis on data acquisition, programming, data editing, data development, data transmission, data analysis, file development, analysis, data and file documentation in support of research, analytic and demonstration projects. CMS' research and analytic and demonstration projects require technical support with their design, development and implementation, particularly computer and related analytical support services to access, assemble, manipulate, process and develop data and files. The data files include those related to the Medicare and Medicaid programs or their operation, as well as those from CMS contracts and grants or from private sector contributors.

Status: This base contract awarded in September 2000 expired in September 2001. Tasks awarded to date are: (TO#1) Health Care Financing Review Index. Individual tasks are described separately.

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis

This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this policy analysis specialty area contract, CMS may award task orders for projects that involve the analysis of policy questions, often within short timeframes, to provide the Government with information and options to guide decisions related to important or urgent policy issues. The base award was for 1 year with a maximum of 4 option years.

00-136 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - Brandeis

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-137 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - C.N.A.

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: C.N.A. Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-141 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - UI

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Urban Institute
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-135 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - Barents

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Barents Group
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-133 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - Abt

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Abt Associates
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO#1) Medicare Behavioral Health Cost and Use Study. Individual tasks are described separately.

00-139 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - Medstat

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: MEDSTAT Group (DC)
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-134 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - ARC

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Actuarial Research Corporation
Funding: $0

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date: (TO# 1) Data Collection to Support Policy Analysis of Choices

Offered to Medicare+Choice Enrollees and Choices Made by Enrollees. Individual tasks are described separately.

00-138 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - MPR

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Mathematica Policy Research, (Princeton)
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-140 Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - RTI

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Research Triangle Institute, (NC)
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO# 1) Market Area Selection and Data Development for Medicare Fee-for Service Reform. Individual tasks are described separately.

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations

This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this Medicare R&D specialty area contract, CMS may award task orders for projects that involve a range of research and demonstration activities. These projects will relate to the Medicare, Medicaid, Child Health programs, the financing and delivery of health services or the quality and appropriateness of health services and associated topics. The tasks can involve the development, analysis, implementation, and/or evaluation of health care financing research and demonstration studies/projects. The base award was for 1 year with a maximum of 4 option years.

00-144 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - CHPR

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Center for Health Policy Research, University of Colorado
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO #1) Improving Protocols for Home Health Agency Assessment in the Survey Process. Individual tasks are described separately.

00-143 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - UI

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Urban Institute
Funding: $0

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO# 1) Next Generation Medicare Managed Care Payment System; and (TO#2) Assessment, Refinement and Analysis of PPS for SNF's. Individual tasks are described separately.

00-142 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - RTI

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Research Triangle Institute, (NC)
Funding: $0

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO#1) Assessment of Medicare Prescription Drugs and Coverage Policies; (TO#2) Questionnaire Development and Cognitive Testing Using Item Response Theory; (TO#3) Analysis of Medicare Beneficiary Baseline Knowledge Data Using the Medicare Current Beneficiary Survey - Phase 3; and (TO#4) Development of Quality Indicators for Inpatient Rehabilitation. Individual tasks are described separately.

00-149 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Brandeis

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Brandeis University, Heller Graduate School, Institute for Health Policy
Funding: $1,000

Status: This is the base task order contract awarded in September 2000. Tasks awarded to date are: (TO #1) Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project. Individual tasks are described separately.

00-146 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - URREA

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: University Renal Research and Education Association
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-155 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Barents

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Barents Group
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO #1) Report to Congress: State Licensure and Certification Standards and Respiratory Therapy Competency Examinations; (TO #2) Implementation Support for the Medicare Participating Centers of Excellence Demonstration; (TO #3) Assessment of Medicare and You Education Program; (TO #4) Impact of Medicare Plus Choice Lock-In Provision; (TO #5) American Indian/Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare. Individual tasks are described separately.

00-147 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Wisconsin

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: University of Wisconsin - Madison
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-148 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - HER

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Health Economics Research
Funding: $1,000

Status: This is the base task order contract awarded in September 2000. Tasks awarded to date are: (TO #1) Environmental Scanning for: Selective Contracting Practices with Efficient (Qualified) Physicians and Physician Group Practices; Profiling Techniques; Incentive Payments; and Barriers to Selective Contracting; (TO #2) Evaluation of BBA Impacts on Medicare Delivery and Utilization of inpatient and Outpatient Rehabilitation Therapy Services; (TO #3) MHSPE Pilot Survey and Analysis. Individual tasks are described separately.

00-154 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - ARC

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Actuarial Research Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-145 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Rand

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: RAND Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-152 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Medstat

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: MEDSTAT Group (DC)
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-151 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - MPR

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Mathematica Policy Research, (Princeton)
Funding: $1,000

Status: This is the base task order contract awarded in September 2000. Task orders awarded to date is: (TO #1) Evaluation of PACE as a Permanent Program and a For-Profit Demonstration. Individual tasks are described separately.

00-153 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - C.N.A.

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: C.N.A. Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO#1) Integrated Chronic Disease Quality Performance Measurement at the Physician Level; and (TO#2) Improving Nursing Home Enforcement. Individual tasks are described separately.

00-150 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Abt

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Abt Associates
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO: #1) Quality Monitoring for Centers of Excellence Demo; (TO #2) Evaluation of Private Fee for Service Plans in the Medicare Plus Choice Program; and (TO #3) Studies in Home Health Case Mix. Individual tasks are described separately.

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations

This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this Medicaid R&D specialty area contract, CMS may award task orders for projects that involve a range of research and demonstration activities. These projects will relate to the Medicare, Medicaid, Child Health programs, the financing and delivery of health services or the quality and appropriateness of health services and associated topics. The tasks can involve the development, analysis, implementation, and/or evaluation of health care financing research and demonstration studies/projects. The base award was for 1 year with a maximum of 4 option years.

00-160 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - Rand

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: RAND Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-157 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - UI

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Urban Institute
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-156 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - RTI

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Research Triangle Institute, (NC)
Funding: $0

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO# 1) Evaluation of the BadgerCare Medicaid Demonstration; and (TO# 2) Research on Systems Changes in Long Term Care. Individual tasks are described separately.

00-165 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - C.N.A.

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: C.N.A. Corporation
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-163 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - Lewin

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Lewin Group
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO #1) Medicaid Payment Accuracy Review Systems. Individual tasks are described separately.

00-159 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - MPR

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Mathematica Policy Research, (DC)
Funding: $0

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO# 01) Disabled and Special Needs Populations: Examining Enrollment, Utilization, and Expenditures. Individual tasks are described separately.

00-158 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - HER

Project Officer: Jackie Wiegman
Period: September 2000–September 2002
Awardee: Health Economics Research
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: (TO #1) Diabetes Care Across the Life Span for Medicaid Beneficiaries: Gender and Racial Differences; and (TO #2) Evaluation of the Demonstration to Maintain Independence and Employment and the Maine Section 1115 HIV/AIDS Waiver (TWWIIA). Individual tasks are described separately.

00-161 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - Abt

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Abt Associates
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

00-162 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - MedStat

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: MEDSTAT Group (DC)
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. Tasks awarded to date are: 01 "Next Generation Medicare Managed Care Payment System." Individual tasks are described separately.

00-164 Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - CHPR

Project Officer: Jackie Wiegman
Period: September 2000–September 2003
Awardee: Center for Health Policy Research, University of Colorado
Funding: $1,000

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2000. There are no tasks awarded to date.

01-166 Active Projects Report; Reconsideration, Revision, and Production Improvements

Project Officer: Linda Lebovic
Period: September 2001–September 2002
Awardee: IQ Solutions, Inc.
Funding: $54,316

Description: The Office of Research, Development, and Information and its predecessor organizations have annually published a book showing the extant research and demonstration projects, both intramural and extramural. The current edition is entitled Active Projects Report: 2001. The structure and presentation format of this publication has not been seriously reviewed for over 10 years. This project takes a careful look at the way this information is presented, i.e., the format and content of the publication, to see if a revision will make the information more accessible to users. This is accompanied by the need to improve the capacity for actual production of the annual book. The first draft copy should generate directly from the database that holds the project information; and the process by which the data on each project is made current needs to be carefully examined and automated to the greatest extent possible. These last two items are directly related to our need to reduce the labor involved first, in updating the information and second, in the actual production of the book.

Status: The overall presentation of the "Active Projects Report" has been reviewed and compared to other, like, publications. Of interest was the finding that there are very few regular publications that display summary information on research projects underway. Also, this general review stimulated the idea that perhaps indicative charts should be intermingled with the descriptions of projects. On the detailed layout of the contents, it was determined that the existing two column format was the most comfortable for the material. Suggestions were made for some font and page layout changes that should improve readability. This process was nearly complete in late December in time to begin detailed programming so that the 2002 version of the "Active Projects Report" could be produced in the new format.

Analysis of Large Data Sets Task Order Contract

This is the base contract under which task orders can be awarded for a wide range of general analysis of data activities. These projects will relate to: Medicare, Medicaid, Managed Care, Long Term Care, children's health insurance, low income and uninsured programs; financing and delivery of health services or quality and appropriateness of health services, and various other associated topics. The contractor can be required to perform tasks involving the analysis of data to assist health care financing research studies or projects. The contractor must have, or must be able to acquire, the resources and expertise to perform these functions on an almost immediate basis. Examples of functions required to be performed under this task order contract are: acquiring and analyzing data; assisting in providing technical assistance or training; pilot testing; framing and designing a project; convening technical expert groups or panels; developing options or issue papers with interim and final reports; conducting actuarial, statistical, and other analyses; preparing administrative clearance packages; meeting with government and non-government groups; abstracting records and other claims/forms; and making presentations when necessary, preparing papers and articles, disseminating findings, literature reviews, etc.

Status: This is the base contract on which subsequent task orders are awarded. It remains active as long an any single task is underway.

01-140 **Analysis of Large Data Sets Task Order Contract - Econometrica**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Econometrica, Inc.
Funding: $1,000

01-132 **Analysis of Large Data Sets Task Order Contract - Acumen**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Acumen, LLC
Funding: $1,000

01-133 **Analysis of Large Data Sets Task Order Contract - HER**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Health Economics Research
Funding: $1,000

01-134 **Analysis of Large Data Sets Task Order Contract - ARC**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Actuarial Research Corporation
Funding: $1,000

01-135 **Analysis of Large Data Sets Task Order Contract - McDonald**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Walter R. McDonald & Associates, Inc.
Funding: $1,000

01-136 **Analysis of Large Data Sets Task Order Contract - JEN**

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: JEN Associates, Inc.
Funding: $1,000

01-137 Analysis of Large Data Sets Task Order Contract - QRS

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Quality Resources Systems
Funding: $1,000

01-138 Analysis of Large Data Sets Task Order Contract - Anasys

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: ANASYS
Funding: $1,000

01-139 Analysis of Large Data Sets Task Order Contract - Klemm

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Klemm Analysis Group, Inc.
Funding: $1,000

01-141 Analysis of Large Data Sets Task Order Contract - Jing Xing

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Jing Xing Technologies
Funding: $1,000

DESIGN AND CONDUCT OF SURVEY TASK ORDER CONTRACTS

This is the base award of an Indefinite Delivery Indefinite Quantity (IDIQ) task order contract. Under this specialty area contract, CMS may award task orders for projects that involve: general survey design and planning; data collection and methodological research; designing and pilot testing questionnaires and other kinds of data collection instruments; conducting general population survey(s) of all kinds including surveys of subsets of the general population; such as the elderly, Medicare and Medicaid recipients (dual eligible beneficiaries), uninsured, and low income families with small children. The base award was for 1 year with a maximum of 4 option years.

Status: This is the base task order contract [indefinite delivery-indefinite quantity contract] awarded in September 2001. There are no tasks awarded to date.

01-119 Design and Conduct of Survey Task Order Contracts - Hope

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Project Hope, Center for Health Affairs
Funding: $1,000

01-124 Design and Conduct of Survey Task Order Contracts - Gallup

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: The Gallup Organization, Government Division
Funding: $1,000

01-131 Design and Conduct of Survey Task Order Contracts - Analytical Sci

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Analytical Science
Funding: $1,000

01-130 Design and Conduct of Survey Task Order Contracts - Jing Xing

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Jing Xing Technologies
Funding: $1,000

01-129 Design and Conduct of Survey Task Order Contracts - HER

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Health Economics Research
Funding: $1,000

01-128 Design and Conduct of Survey Task Order Contracts - Anasys

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: ANASYS
Funding: $1,000

01-127 Design and Conduct of Survey Task Order Contracts - MPR

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Mathematica Policy Research, (DC)
Funding: $1,000

01-125 Design and Conduct of Survey Task Order Contracts - AIR

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: American Institute for Research
Funding: $1,000

01-123 Design and Conduct of Survey Task Order Contracts - Abt

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Abt Associates
Funding: $1,000

01-122 Design and Conduct of Survey Task Order Contracts - Westat

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Westat Corporation
Funding: $1,000

01-121 Design and Conduct of Survey Task Order Contracts - NORC

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: NORC
Funding: $1,000

01-120 Design and Conduct of Survey Task Order Contracts - RTI

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: Research Triangle Institute, (NC)
Funding: $1,000

01-126 Design and Conduct of Survey Task Order Contracts - RAND

Project Officer: Jackie Wiegman
Period: September 2001–September 2002
Awardee: RAND Corporation
Funding: $1,000

02-080 **ADP Services Supporting Research, Analysis and Demonstration Activities–Base Contract**

Project Officer: Jackie Wiegman
Period: September 2002–September 2007
Awardee: CHD Research Associates
Funding: $0

Description: CMS's research, analytic and demonstration projects require computer and related support services to access, manipulate, process and develop data and files. The data files include those derived from the Medicare and Medicaid programs as well as those from CMS contracts and grants or from other sources. Current and anticipated internal resources are insufficient to handle the range and quantity of requirements that arise from these project and from projects that will occur in the future.

Status: In AGG 4/1/02.

02-053 **Evaluation of the Dialysis Facility Compare Website**

Project Officer: Eileen Zerhusen
Period: September 2002–September 2003
Awardee: Research Triangle Institute, (DC)
Funding: $524,141

Description: This project will evaluate the usefulness of the quality and descriptive information on the Dialysis Facility Compare (DFC) Web site for patients with End Stage Renal Disease (ESRD), families of patients with ESRD, ESRD professionals, members of the ESRD industry, and other stakeholders.

98-277 **Implementing the HEDIS© Medicare Health Outcomes Survey**

Project Officer: Chris Haffer
Period: September 1998–October 2002
Awardee: National Committee for Quality Assurance
Funding: $476,678

Description: The Medicare Outcomes Survey (HOS) is the first outcome measure and largest survey used by CMS and was implemented in 1998. The survey is fielded nationally as a Health Plan Employer Data Set (HEDIS©) measure. It is a longitudinal, self-administered survey which utilized the SF-36 (assesses physical and mental functioning) and additional case mix adjustment variables. Each year, survey data are collected for a new sample (cohort) of Medicare managed care beneficiaries. Members that respond to the baseline survey are resurveyed two years later in a followup. The goals of the Medicare HOS are 1) to help beneficiaries make informed health care choices and 2) to promote quality improvement based on competition. 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 actually administered through a group of certified vendors.

Status: Cohort four baseline data and cohort two remeasurement data were successfully collected from over 200,000 beneficiaries in 2001. Survey vendors will be certified in February 2002. The fielding of cohort 5 baseline and cohort 3 remeasurement will occur in spring 2002.

99-140 **Medicare Health Outcomes Survey Applied Research Center**

Project Officer: Patricia Wright-Gaines
Period: September 1999–October 2002
Awardee: Health Services Advisory Group
Funding: $1,529,185

Description: This is a special study to support the implementation of the Medicare Health Outcomes Survey (HOS). The project produces special reports, public use files, analytical support, and consultative technical assistance. It uses HOS baseline and followup data supplemented by other data sources.

Status: In 2001, the first public use file was created from the cohort 1 baseline data. Subsequent public use files will be released in 2002. Technical reports were produced of the health status of disabled and dual eligible Medicare beneficiaries, enrollment duration, and a comparison of proxy respondents to

self-respondents. Other special reports, including incidence of depression, are in various stages of production. Activities underway in 2002 include an evaluation of Medicare+Choice plans from cohort 1 that have outlier scores for the Mental Health Component Summary and the redesign and support of the Medicare HOS page on CMS's web site.

02-074 Active Project Report: Annual Production

Project Officer: Linda Lebovic
Period: June 2002–June 2003
Awardee: IQ Solutions, Inc.
Funding: $29,000

Description: The "Active Projects Report" is an annual publication listing research and demonstration projects funded by the Centers for Medicare & Medicaid Services. Until the 2001 edition, this was done by intramural staff at substantial expense [measured in staff hours]. As of the 2002 edition, the first draft now generates directly from the database that holds research and demonstration project information. This copy needs to be edited and readied for printing. This project has two purposes for future editions: 1) to produce the book, including a template to convert the database file to print-ready copy and 2) to do so more efficiently than through the use of intramural staff.

Status: This is an annual publication.

02-075 Convert CMS Research Results to Consistent Standardized Architecture to Support Web-Based Dissemination (with two Options)

Project Officer: Eric Katz
Period: June 2002–June 2003
Awardee: IQ Solutions, Inc.
Funding: $51,000

Description: This project provides review, assessment and planning activities that support CMS' building a web-based capacity to disseminate the findings of our research and the information. Some of the preparatory work which makes this possible has already been done for some of our products, e.g., the Health Care Financing Review, and moving the database on research and demonstration projects to a web-based application.

Status: In ORDI clearance process March 25, 2002.

MANDATE AND AUTHORITY

Acronym	Short Description	Legislative Citation	Description of Mandate
2000 Appropriations Act	HHS/Labor 2000 Appropriations Act		There is an earmark in the annual appropriations act for this specific project or category of projects or this awardee.
2001 Appropriations Act	HHS/Labor 2001 Appropriations Act		There is an earmark in the annual appropriations act for this specific project or category of projects or this awardee naming the level of funding.
2002 Appropriations Act	HHS/Labor 2002 Appropriations Act		There is an earmark in the annual appropriations act for this specific project or category of projects or this awardee.
ADA	Americana with Disabilities Act	ADA Title II	Olmstead v L.C. and Executive Order 13217 requires that the Federal government assist States ensure that Americans of all ages with a disability or long-term illness have the opportunity to live and participate in their community, in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
BBA	Balanced Budget Act of 1997 - Medicare, Medicaid, and Children's Health Provisions - Medicare+Choice Program		Amends title XVIII (Medicare) of the Social Security Act (SSA) to establish a Medicare+Choice program under which each Medicare+Choice eligible individual (one entitled to benefits under Medicare part A (Hospital Insurance) and enrolled under Medicare part B (Supplementary Medical Insurance)) is entitled to elect to receive Medicare benefits either through the original Medicare fee-for-service program or through a Medicare+Choice plan.
BBA - CNO	Balanced Budget Act of 1997 - Community Nursing Organizations	Public Law 105-33 Section 4019	Extends for an additional 2 years certain Medicare community nursing organization demonstration projects under the Omnibus Budget Reconciliation Act of 1987.
BBA - Coordinated Care Demo	Balanced Budget Act of 1997 - Coordinated Care Demonstration	Public Law 105-33 Section 4016	Requires a demonstration project for the Medicare fee-for-service population to evaluate models of coordinated care that improve the quality of services provided to specific beneficiaries with a chronic illness and manage expenditures under Parts A and B of the Medicare program.
BBA - Diabetes	Balanced Budget Act of 1997 - Diabetes Benefits	Public Law 105-33 Section 4105	Directs the Secretary to establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for the purpose of evaluating the improvement of health status of Medicare beneficiaries with diabetes mellitus, with a view to recommending coverage modifications.
BBA - Durable Medical Equipment	Balanced Budget Act of 1997 - Durable Medical Equipment	Public Law 105-33 Section 4319	Permits the selection of a sufficient number of suppliers in each product category to meet the projected demand at the demonstration sites. Those suppliers selected as demonstration suppliers are the only ones eligible to receive Medicare payments for supplying DME under the demonstration.

Acronym	Short Description	Legislative Citation	Description of Mandate
BBA - EPSDT	Balanced Budget Act of 1997 - Early and Periodic Screening for Diagnosis and Treatment	Public Law 105-33 Section 4744	Requires study and report to the Congress on early and periodic screening, diagnostic, and treatment benefits.
BBA - Federal Payments to States	Balanced Budget Act of 1997 - Federal Payments to States	Public Law 105-33 Sections 4721, 4722, 4723, 4724, 4725, 4726	Includes reforming DSH, additional funding for State Emergency Health Services, DME, and FMAP.
BBA - GME	Balanced Budget Act of 1997 - Graduate Medical Education	Public Law 105-33 Sections 4624-4630	Revises requirements for direct and indirect Medicare payments for graduate medical education (GME). Limits the number of residents in allopathic and osteopathic medicine. Permits payment to qualified nonhospital providers for direct GME costs. Prohibits restandardization of certain indirect GME payment amounts. Requires direct and indirect GME payments to hospitals for Medicare+Choice enrollees. Makes a special reimbursement rule for primary care combined residency programs, setting the period of board eligibility.
BBA - Medicare+Choice	Balanced Budget Act of 1997 - Medicare+Choice	Public Law 105-33 Section. 4001	Outlines the types of Medicare+Choice plans that may be available: (1) coordinated care plans; (2) combination of a medical savings account (MSA) plan and contributions into a Medicare+Choice MSA; and (3) private fee-for-service plans.
BBA - PACE	Balanced Budget Act of 1997 - Program for All Inclusive Care for the Elderly	Public Law 105-33 Section 4801 Paragraph 1894	Amends SSA Title XVIII to provide for Medicare programs of all-inclusive care for the elderly (PACE programs) for individuals age 55 or older who require the level of care required under the State Medicaid plan for coverage of nursing facility services.
BBA - PPS	Balanced Budget Act - Prospective Payment System	Section 4421 of the Balanced Budget Act of 1997 (P.L. 105-217)	This section requires the development of a PPS for inpatient rehabilitation hospitals services for Medicare patients. This PPS covers operating and capital costs of inpatient hospital services of a rehabilitation hospital or an exempt rehabilitation unit of an acute-care hospital and is implemented with cost-reporting periods beginning October 2000. In particular, it mandates classes of patients of rehabilitation facilities (each group in this subsection referred to as a case mix group), based on such factors as impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient and a method of classifying specific patients in rehabilitation facilities within these groups.
BBA - Prevention	Balanced Budget Act of 1997 - Prevention Initiatives	Public Law 105-33 Sections 4101, 4102. 4103, 4104, 4106, 4107, 4108	Outlines various specified new preventive health measures covered under Medicare, namely coverage for: (1) an annual screening mammography for women over age 39 and triennial screening pap smear and screening pelvic exam for any woman; (2) annual prostate cancer screening tests; (3) colorectal cancer screening tests; (4) diabetes outpatient self-

Acronym	Short Description	Legislative Citation	Description of Mandate
			management training services, including blood-testing strips and glucose monitors as durable medical equipment (DME) for individuals with diabetes; and (5) bone mass measurements.
BBA - Private Contracting	Balanced Budget Act of 1997 - Private Contracting with Medicare Beneficiaries Provision	Public Law 105-33 Section 4507	Certain physicians and practitioners may privately contract with Medicare beneficiaries if the physician or practice files an affidavit with Medicare opting out of the program for 2 years.
BBA - Quality	Balanced Budget Act of 1997 - Quality Assessment and Improvement Strategy	Public Law 105-33 Sections 4705	Amends Social Security Act Title XIX (Medicaid) to require any State contracting with Medicaid managed care organizations to develop and implement a quality assessment and improvement strategy incorporating certain access standards, monitoring procedures, and other measures. Directs the Comptroller General to analyze and report to specified congressional committees on the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or under Medicare contracts to determine if such programs and standards consider the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals.
BBA - Rural Health	Balanced Budget Act of 1997 - Rural Initiatives	Public Law 105-33 Subtitle C: Sections 4201, 4102, 4103, 4016	Replaces the Essential Access Community Hospital Program with an optional Medicare Rural Hospital Flexibility Program under which participating States develop at least one rural health network in the State and at least one facility designated as a critical access hospital in accordance with prescribed guidelines. Authorizes grants to States for: (1) planning and implementation of the program; and (2) establishment or expansion of rural emergency medical services.
BBA - SHMO	Balanced Budget Act of 1997 - Social Health Maintenance Organization (SHMO)	Public Law 105-33 Section. 4014	Amends the Omnibus Budget Reconciliation Act of 1987 to extend the authorities for the social health maintenance organization (SHMO) demonstration project. Amends the Omnibus Budget Reconciliation Act of 1993 to increase the cap on the number of individuals who may participate in a SHMO demonstration. Directs the Secretary to submit to the Congress a plan for the integration of SHMO health plans and similar plans as an option under the Medicare+Choice program.
BBA - Subvention	Balanced Budget Act of 1997 - Medicare Subvention Project for Military Retirees	Public Law 105-33 Sections 4015	Authorizes the HHS Secretary and the Secretary of Veterans Affairs to establish a demonstration (subvention) project under which the HHS Secretary shall reimburse the Secretary of Veterans Affairs from the Medicare trust funds for Medicare health care services furnished to certain targeted Medicare-

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Acronym	Short Description	Legislative Citation	Description of Mandate
			eligible military retirees or dependents. Authorizes the Secretary of Defense to modify existing TRICARE contracts in order to provide Medicare health care services to project participants.
BBA - Telemedicine, Informatics Demo	Balanced Budget Act of 1997 - Telemedicine (Rural Health)	Public Law 105-33 Section 4207	Established a single, 4-year demonstration project using an eligible health care provider telemedicine network.
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999	Incorporated into Public Law 106-113	Modifies some of the payment reductions of Balanced Budget Act.
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	Public Law 106-554	Provisions include modifications to the Disproportionate Share Hospital (DSH) program (Section 701), SCHIP allotments, Graduate Medical Education (GME) program. Changes in Medicare coverage and appeals process (Section 521). Revisions to Medicare coverage process, home health payment systems. Managed care reforms. Implemented Tricare Senior Pharmacy Program; conditions for eligibility for Champus and Tricare (Age 65), modified Medicare Subvention Project.
BIPA - Demonstration Projects and Studies	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	Public Law 106-554 Subtitle C	Outlines: (1) a demonstration project for disease management for severely chronically ill Medicare beneficiaries; (2) demonstration projects for cancer prevention and treatment for ethnic and racial minorities; (3) a National Academy of Sciences study of the addition of coverage of routine thyroid screening using a thyroid stimulating hormone test as a preventive benefit provided to Medicare beneficiaries; (4) a Medicare Payment Advisory Commission (MedPAC) study on consumer coalitions in marking Medicare+Choice plans; (5) a study on the effect of limitations on State payment for Medicare cost-sharing on access to services for qualified Medicare beneficiaries; (6) studies on preventive interventions in primary care for older Americans; (7) a MedPAC study on Medicare coverage of cardiac and pulmonary rehabilitation therapy services; and (8) the Lifestyle Modification Program Demonstration project.
Boren Repeal	Balanced Budget Act of 1997 - Repeal of the Boren Amendment	Public Law 105-33 Section 4711	Repeals "Boren Amendment" provider reimbursement requirements. Requires study and report on the effect on access to services, service quality, and service safety of the rate-setting methods used by States as a result of such repeal.

Acronym	Short Description	Legislative Citation	Description of Mandate
Breast and Cervical Cancer Prevention and Treatment Act	Breast and Cervical Cancer Prevention and Treatment Act of 2000	Public Law 106-354	
CAA	Consolidated Appropriations Act of 2001	Public Law 106-554	
Cancer Registries Act	The Cancer Registries Act	Public Law 102-515	This Act requires the establishment of a national program of cancer registries, with the overall goal being the assurance of minimal standards for quality and completeness of (cancer) case information.
CCA '88	Medicare Catastrophic Coverage Act of 1988	Public Law 100-360	
CLIA	Clinical Laboratory Improvement Amendments	Public Law 100-578 amended Section 353 of the Public Health Service Act (42 U.S.C. 263a), the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to include all laboratories that examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings.	Requires CMS to regulate all laboratory testing (except research) performed on humans in the U.S. The objective is to ensure quality laboratory testing by meeting certain requirements. Many are based on the complexity of the tests performed. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.
COBRA	Consolidated Omnibus Budget Reconciliation Act	Public Law 99-272, Section 9113	Requirement of a review of and report on the impact of Medicare hospital payment policies for outliers and patient transfers to rural hospitals, particularly hospitals with less than 100 beds.
Deficit Reduction Act '84			This act was the first authorization for the Social/Health Maintenance Organization demonstrations.
Dual Eligibles	Persons eligible for both Medicare and Medicaid benefits.		These persons account for about one in six beneficiaries but for about a third of all spending in both programs. Dual eligibles tend to be older, sicker, and more likely to be in a nursing home than persons only entitled to Medicare. States are required to pay some or all Medicare cost-sharing (premiums, deductibles, and coinsurance) for certain low-income

Acronym	Short Description	Legislative Citation	Description of Mandate
			Medicare beneficiaries. The scope of the cost-sharing benefits, and the Federal-State funding shares, vary by beneficiary income as a percent of poverty. In addition, States may pay full Medicare cost-sharing for beneficiaries that meet State-defined Medicaid eligibility criteria.
EACH/RPCH	Section 1820 of the Social Security Act	Public Law 101-239	Essential Access Community Hospital/Rural Primary Care Hospital Program
EPSDT	The Early and Periodic Screening, Diagnostic, and Treatment	EPSDT was defined in the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). Social Security Act Section 1905(r)(5)	In 1967 - EPSDT comprehensive health services benefit for all Medicaid children under age 21 was established. OBRA'89 expanded EPSDT requirements to include Medicaid coverage of pregnant women and children under age 6 whose family income was at or below 133 percent of the FPL.
Health Promotion and Disease Prevention Amendments	The Health Promotion and Disease Prevention Amendments of 1984	Public Law. 98-551	This amended the Public Health Service (PHS) act to extend provisions relating to health promotion and disease prevention and to establish centers for research and demonstration in those areas.
HIFA	Health Insurance Flexibility and Accountability	Social Security Act Section 1115	A demonstration initiative—newly developed Medicaid and State Children's Health Insurance Program (SCHIP) section 1115 waiver approach. The primary goal of HIFA is to encourage new comprehensive State approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources.
HIPAA	Health Insurance Portability and Accountability Act of 1996	Public Law 104-191	HHS, the Department of Labor, and the Department of Treasury each have roles in implementing the insurance reform provisions of this Act. CMS works with States to comply with the small group and individual market provisions of HIPAA. The law is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. For the first time, HIPAA applies the same rules governing portability of health insurance coverage across the large group, small group, and individual insurance markets. It limits the application of pre-existing condition clauses and imposes requirements concerning mental health parity. HIPAA also provided CMS with new tools to fight fraud and abuse and dedicated mandatory funding for Medicare's fraud and abuse activities under the Medicare Integrity Program. HIPAA established "administrative simplification" requirements for electronic data standards applicable to the entire healthcare industry. HIPAA mandated that HHS adopt national standards for electronic health care transactions and code sets, and that all (public and private) health plans, clearinghouses, and those

Acronym	Short Description	Legislative Citation	Description of Mandate
			providers doing business electronically be mandated to use these standards. These standards include formats and data content for administrative transactions (e.g. claims, eligibility inquiry and response, enrollment); national identifiers for health plans, providers, and employers; privacy and security protections for the data.
Home Health Care and Alzheimer's Disease Amendments	Home Health Care and Alzheimer's Disease Amendments of 1990	Public Law 101-557	The amendments broadened the authority for Alzheimer's disease research centers and authorized Claude D. Pepper Older Americans Independence Centers grants.
M+C - Competitive Pricing	Balanced Budget Act of 1997 - Medicare+Choice (Part C) -	Public Law 105-33 Sections 4011, 4012, 4013, 4317, 4319	HMO competitive pricing demonstrations, SHMO demonstrations. Sections 4317 and 4319 mandate competitive bidding demonstration projects concerning fraud and abuse.
M+C - Eligibility, Enrollment, Information and Marketing	Balanced Budget Act of 1997 - Medicare+Choice (Part C)	Public Law 105-33 Section 4001 Paragraph 1851	While Medicare has contracted with Health Maintenance Organizations (HMO) on a risk basis since 1987, the Balanced Budget Act of 1997 (BBA) added Part C to Medicare (known as Medicare+Choice), expanding the types of private health plans (such as private fee-for-service, Medical Savings Accounts, Preferred Provider Organizations, and Point of Service Plans) with which CMS can contract (though few of these types of plans actually participate in Medicare). Medicare+Choice permits Medicare beneficiaries to select health plans, available in most areas of the country, where beneficiaries may go to doctors, specialists, or hospitals who participate in the plan. Some managed care plans cover extra benefits, like outpatient prescription drugs and hearing aids. About six million Medicare beneficiaries currently are enrolled in such health plans.
M+C - Payment	Balanced Budget Act of 1997 - Medicare+Choice (Part C)	Public Law 105-33 Section 4001 (Paragraph 1853), Sections 4401-4441	This mandated a new methodology for payment to Medicare risk contractors by January 2000. The BBA further provided the authority for the collection of inpatient and other encounter data. This addresses the concern of selection bias in the Medicare+Choice program, that is a number of studies by CMS and other nongovernment researchers have shown that Medicare+Choice (M+C) plans have historically been overpaid. This is because payment has been based on a demographic model or an average fee-for-service Medicare beneficiary, and evidence shows that M+C plans enroll healthier than average beneficiaries. In response to industry concerns regarding the financial impact, a transitionary payment schedule was developed beginning in 2000 with payment based on a 90% demographic (the old method) and 10% PIP-

Acronym	Short Description	Legislative Citation	Description of Mandate
			DCG risk adjusted payment blend. The Balanced Budget Refinement Act (BBRA) of 1999 mandated a slower phase-in schedule for risk adjusted payment for 2001 and 2002 than the one announced by CMS. Sections 4401-4441
M+C - Standards, Coverage, Grievance and Appeals	Balanced Budget Act of 1997 - Medicare+Choice (Part C)	Public Law 105-33 Section 4001 Paragraph 1852	
Medicaid	Medicaid -- Grants to States for Medical Assistance Programs	Social Security Act Title XIX (42 U.S.C. 1396)	Enabled each State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services; and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. The funds made available under this section shall be used for making payments to States, which have submitted, and had approved State plans for medical assistance.
Medicaid	Medicaid was enacted in 1965 to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.	Title XIX of the Social Security Act	Late in the legislative process leading the Medicare program for the aged, a replacement for the existing medical assistance program was added and called "Medicaid." This covered the categorically needy. In 1972: The newly enacted Federal Supplemental Security Income program (SSI) provided States the opportunity to link to Medicaid eligibility for elderly, blind, and disabled residents. In 1986: Medicaid coverage for pregnant women and infants (aged 1 year or under) whose family income was at or below 100 percent of the Federal poverty level (FPL) was established as a State option.
Medicaid Managed Care	Balanced Budget Act of 1997 - Medicaid Managed Care	Public Law 105-33 Subtitle H Sections 4702 - 4708	Amends SSA title XIX (Medicaid) to establish a new part B (Managed Care) giving States the option to require Medicaid-eligible individuals (except Medicare beneficiaries, Medicare-eligible individuals, and certain children with special needs) to enroll in managed care arrangements of the individual's choice as a condition of receiving Medicaid.
Medicare	Medicare was enacted in 1965 to cover the elderly.	Social Security Act Title XVIII (42 U.S.C. 1395)	Seniors were the population group most likely to be living in poverty; about half had insurance coverage.
Medicare Modernization	Medicare Modernization Act of 2000		This Administration Proposal: (1) made Medicare more competitive and efficient; (2) modernized and reformed Medicare's benefits, including adding a prescription drug benefit and eliminating cost sharing for preventive benefits; and 3) extended the life of the Medicare trust funds.
OBRA '80	Omnibus Budget Reconciliation Act of 1980	Public Law 96-499, Section 958	Study of coverage for services of registered dietitians' services in the home.

Acronym	Short Description	Legislative Citation	Description of Mandate
OBRA '86	Omnibus Budget Reconciliation Act of 1986	Public Law 99-509	
OBRA '87	Omnibus Budget Reconciliation Act of 1987	Public Law 100-360	A bill to amend title XVIII (Medicare) of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and created a prescription drug program. This was later rescinded.
OBRA '89	Omnibus Budget Reconciliation Act of 1989	Public Law 100-360	Required research on issues relating to the delivery and financing of Medicare long-term care services. Mandated a survey of adult day care services and report to the Congress. Made technical corrections to certain health care provisions in OBRA'87. Established a demonstration project to: (1) provide training and technical assistance to prepare volunteers to counsel elderly Medicare or Medicaid beneficiaries regarding their eligibility for such benefits and assist such beneficiaries in applying for those benefits; and (2) reimburse volunteers for expenses incurred in receiving such training or providing such services. Mandated four 2-year demonstration projects to provide case management services to Medicare beneficiaries with selected high cost catastrophic illnesses.
OBRA '89	Omnibus Budget Reconciliation Act of 1989	Public Law 101-239	Established a demonstration program for (1) planning and implementing a rural health care plan and rural health networks; (2) designating hospitals or facilities as essential access community hospitals or rural primary care hospitals; and (3) developing and supporting communication and emergency transportation systems. Authorized hospitals and facilities in grant States to apply, subject to the State's approval, finance the costs it incurs in converting itself to a primary care hospital or in becoming part of a rural health network in the State in which it is located. Required that hospitals designated as essential access community hospitals be isolated rural hospitals that have at least 75 inpatient beds and provide emergency and medical backup services to rural primary care hospitals in their rural health network and throughout their service area. Required that rural primary care hospitals provide 24-hour emergency care and no more than 72 hours of inpatient care for no more than six inpatients.
OBRA '90	Omnibus Budget Reconciliation Act of 1990	Public Law 101-508	Amended the Medicare program to change hospital prospective payment rate; the market basket percentage for hospitals located in urban areas, and for hospitals located in rural areas. Increased disproportionate share payments for urban hospitals.

Acronym	Short Description	Legislative Citation	Description of Mandate
			Required prospective payment system for the operating and capital-related costs of inpatient hospital services and skilled nursing facilities.
OBRA '92	Omnibus Budget Reconciliation Act of 1992 - Medicare and Medicaid Amendments Act of 1992	102 - S.3274 HR.11	Make miscellaneous technical amendments to Social Security Act titles XVIII (Medicare) and XIX (Medicaid), as well as to various other Medicare- and Medicaid-related provisions in the Omnibus Budget Reconciliation Acts of 1986, 1987, 1989, and 1990. Amendments to Medicare Program – Amends OBRA'89 to provide that all hospitals classified as regional referral centers on September 30, 1992 retain such status through September 30, 1994. Provides that hospitals which fail to qualify as regional referral centers for FY 1993 as a result of a decision by the Medicare Geographic Classification Review Board shall be provided an opportunity to decline the reclassification. Prohibits the revising standardized amounts to account for hospitals which decline the reclassification.
OBRA '93 - Medicare	Omnibus Budget Reconciliation Act of 1993	Public Law 103-66 Chapter 2 Subchapter A	Relating to Part A – Amended title XVIII (Medicare) of the Social Security Act to: (1) reduce and otherwise revise certain prospective payment system (PPS) and other factors used in updating payments to hospitals for inflation (including factors used in updating inflationary payments for sole community and Medicare-dependent, small rural hospitals); (2) prohibited the reductions in granting exceptions or adjustments to target amounts for PPS-exempt hospitals; (3) required the reduction of Federal rate for hospital capital expenses and, for hospital cost reporting periods beginning in FY 1994, redetermine capital payment methodology; (4) extended additional payments (although modified) to Medicare-dependent, small rural hospitals which serve a disproportionate share of low-income patients; (5) delayed inflationary updates in skilled nursing facility (SNF) cost limits; (6) reduced the factors used in updating payments to hospices for inflation; (7) considered intern and resident services performed in a hospital-owned or-controlled community health center whose costs are incurred by the hospital in determining any additional payments to the hospital for indirect medical education costs; and (8) reduced the Medicare part A (Hospital Insurance) premium, on a phased-in graduated basis, for certain individuals credited with 30 or more quarters of social security coverage and their spouses. Coverage was extended to a specific group of self-administered oral anti-cancer drugs. Coverage was expanded to include oral anti-emetic drugs of the and for a specific group of anti-cancer drugs called Prodrugs.

Acronym	Short Description	Legislative Citation	Description of Mandate
Olmstead	Olmstead v. L.C. Decision (1999)	The Supreme Court decision in Olmstead v. L.C.	This Supreme Court decision requires States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The scope of the Americans With Disabilities Act (ADA) and the Olmstead decision are not limited to Medicaid beneficiaries or to services financed by the Medicaid program. The ADA and the Olmstead decision apply to all qualified individuals with disabilities regardless of age. On June 18, 2001, the President signed Executive Order No. 13217 on Community-Based Alternatives for Individuals with Disabilities. The Order commits the United States to community-based alternatives for individuals with disabilities and recognizes that such services advance the best interests of the United States.
Olmstead	July 1999, Supreme Court decision, Olmstead v. L. C.	Olmstead v. L. C.	The Olmstead decision interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Court's decision in that case clearly challenges Federal, State, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.
Original Medicare	Medicare -- Health Insurance for the Aged and Disabled	Social Security Act, Section XVIII	This phrasing came into use in the late 1990's. It refers to the fee-for-service Medicare program as originally structured, with two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part A helps pay for inpatient hospital services, skilled nursing facility services, certain home health services, and hospice care. Medicare Part B helps pay for doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies. Generally, outpatient prescription drugs are not covered. Since its inception, Medicare has contracted with insurance companies to administer the program. A Fiscal Intermediary (FI) is a private company with which Medicare contracts to pay hospitals, skilled nursing facilities, and home health agencies for their Part A and some Part B bills. A Carrier is a private company that Medicare contracts with to pay physicians and other suppliers for their Part B bills.
PRWOR	The Personal Responsibility and Work Opportunity Act of 1996	Public Law 104-193	This eliminated the Aid to Families with Dependent Children (AFDC) program and replaced it with a block grant program for temporary assistance for needy families (TANF).

Acronym	Short Description	Legislative Citation	Description of Mandate
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996	SSA Title XIX Section 1931	Section 1931 of Title XIX as added by Section 114 of PRWORA, continued Title XIX waivers under Section 1115 welfare reform demonstrations, budget neutrality, evaluation requirements, and the process to continue waivers.
QMB	Qualified Medicare Beneficiary	The Medicare Catastrophic Coverage Act of 1988; Public Law 105-33 (BBA) Section 4714	1988: The Qualified Medicare Beneficiary (QMB) eligibility rule required States to provide Medicaid coverage for pregnant women and infants whose family income was at or below 100 percent of the FPL. The criteria established special eligibility rules for institutionalized persons whose spouse remained in the community to prevent "spousal impoverishment."
Quality Improvement Organization (formerly PRO) Program	The Peer Review Improvement Act established Peer Review Organizations (now called Quality Improvement Organizations).	Public Law 97-248	Under the QIO (formerly PRO) program, CMS contracts with independent physician organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting.
Ryan White Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990	Public Law 101-381	This act authorized demonstration grants to community health centers and other entities providing primary health care and servicing a significant number of pediatric patients and pregnant women with HIV disease.
Ryan White CARE Reauthorization Act	The Ryan White CARE Reauthorization Act of 1996	Public Law 104-146	This revised and extended authorization of the 1990 act, which provided for care and services for persons living with HIV/AIDS. Title IV provisions required grant programs to provide health care and opportunities for women, infants, children, and youth to participate as voluntary subjects of clinical research on HIV disease that is of potential benefit to them.
SBIR	The Small Business Innovation Development Act	Small Business Innovation Development Act of 1982 (Public Law 97-219); as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443) Law 97-219; as amended by the Small Business Innovation Research Program, Extension, Public Law 99-443), The Small Business	This Act required that each Federal agency with an annual research and development budget exceeding $100 million set aside a certain portion of its extramural R&D budget for a Small Business Innovation Research (SBIR) program.

Acronym	Short Description	Legislative Citation	Description of Mandate
		Innovation Research and Development and Enhancement Act of 1992 Public Law 102-564	
SBIR 92 Reauthorization	The Small Business Innovation Research and Development and Enhancement Act of 1992	Public Law 102-564	The act reauthorizes the SBIR program through September 30, 2000, and increases set aside percentages for each Federal agency with an extramural budget for research and development in excess of $100 million in FY 1992 (1.25 percent) upward to 2.5 percent by 1997 and onward. Legislation also requires enhancement of agency outreach efforts to increase participation of women-owned and socially and economically disadvantaged small business concerns, and tracking of awards to document their participation in the program.
SCHIP	The State Children's Health Insurance Program, Title XXI; Balanced Budget Act of 1997.	Public Law 105-33 Section 4901 (42 U.S.C. 1397aa)	The SCHIP program is the most significant improvement in access to health care for children since the creation of Medicaid, currently covering about 2 million out of the estimated 11 million uninsured children in the U.S. SCHIP is a capped entitlement for States, funded by a State-Federal partnership. Congress appropriated $24 billion over 5 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance. All States are participating in the SCHIP program. CMS has worked in concert with many partners, in the public and private sectors, to encourage eligible families to sign their children up for coverage.
Section 1115 - HIFA		SSA Section 1115	Gives HHS broad discretion in waiving certain sections of the Social Security Act for the purposes of an experimental, pilot, or demonstration project. This authority allows States to pursue projects under Medicaid and SCHIP that test new and innovative ideas relating to, for example, eligibility requirements, benefit package, service delivery, beneficiary financial responsibilities, and program payment. Since the early 1990's, States have used section 1115 authority under Medicaid. In 2000, states were given permission to also use the authority under SCHIP. Many States have used this authority under Medicaid and SCHIP to expand eligibility, thereby reducing the number of uninsured in their State. Despite these expansions, the uninsured continue to be a major health policy issue and HIFA was designed to aid in addressing the problem.
SLMB	Specified Low-Income Medicare Beneficiary		1990: The Specified Low-Income Medicare Beneficiary (SLMB) eligibility group was established to provide Medicaid coverage for children ages 6 through 18 whose family income was at or below 100 percent of the FPL.

Acronym	Short Description	Legislative Citation	Description of Mandate
SSA - Section 1110 - Dissertation	Authority for Fellowship Dissertation Grant Program		
SSA - Title XXI	Title XXI - The State Children's Health Insurance Program	Title XXI Section 4901 established the program; and amended by the D.C. Appropriations Bill (Public Law 105-100)	The Social Security Act was amended to include a new title: `TITLE XXI--STATE CHILDREN'S HEALTH INSURANCE PROGRAM
SSA '67 Amendment - Section 402		Section 402 of the 1967 Amendments to the Social Security Act	This amendment stimulated the development of demonstration projects. Previously the Act has envisioned the use of trust fund monies for research and reports but not demonstrations.
SSA '83 Amendment			
SSA Section 1915 - Medicaid	In 1981, Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were mandated.	(1915b) freedom of choice waivers; (1915c) community-based care waivers	There is no authority under 1915(b) to cover individuals in a special eligibility category (the 42 CFR 435.217 group) who are only Medicaid eligible through a link to a 1915(c) waiver. For these reasons, several States have opted to simultaneously utilize authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations.
SSA, '94 Amendment	Social Security Act Amendments of 1994	Public Law 103-432, Sections 122, 135, 106	Section 122 required the (1) review and revision of the geographic practice cost indices; (2) use of the most recent available data on practice and malpractice expenses and physician work effort in establishing such indices; and (3) study and report to the Congress on index construction, data used for indices revision, and other related specified matters. Section 135 required the collection and reporting on Durable Medical Equipment (DME) supplier costs and analysis to determine costs attributable to service and product components and the extent to which they vary by type of equipment and geographic region. Section 106 required the collection of data necessary to compute a wage index based on wages specific to skilled nursing facilities.
SSA, Section 1115	1115 Waivers	Social Security Act Section 1115	Section 1115 of the Social Security Act provides CMS with broad authority to authorize experimental, pilot, or demonstration project(s) which are likely to assist in promoting the objectives of the Medicaid statute.
Survey & Certification	Survey and Certification		CMS performs a number of quality-focused activities that benefit all Americans. These activities include minimum quality standards through the survey and certification of health care facilities (including nursing homes, home health agencies, intermediate care facilities for the mentally retarded, and hospitals). State surveyors visit a certain number of facilities each year to determine compliance with CMS quality standards and investigate complaints from the public.

Acronym	Short Description	Legislative Citation	Description of Mandate
			CMS also regulates all laboratory testing (whether provided to beneficiaries of CMS programs or to others) under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
TANF	Temporary Assistance to Needy Families	Public Law 104-193	In 1996, the Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant. The welfare link to Medicaid was severed and enrollment (or termination) of Medicaid was no longer automatic with the receipt (or loss) of welfare cash assistance.
TEFRA	The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)		TEFRA excluded rehabilitation hospitals from the PPS based on a diagnosis-related groups (DRG) system that was implemented in acute-care hospitals. At that time, Congress determined that the DRG system did not predict resource use in rehabilitation hospitals very well. As with other post-acute services, functional and cognitive measures are more related to rehabilitation resource use than diagnosis alone. Under TEFRA, payment for Medicare inpatient rehabilitation hospital care is based on actual cost compared to a per-case target amount that is calculated from the facility's historical cost trended forward. If the costs are less than the target amount, the hospital receives its cost plus an incentive payment. If the costs are greater than the target amount, the hospital receives its cost minus a penalty. This system does not contain any adjustments for case-mix or the intensity of services required for different patients' needs. This current system has been criticized because it seems to favor newer facilities.
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999		Title II of TWWIIA mandated (1) the establishment of two new Medicaid eligibility groups covering working disabled people; (2) Medicaid Infrastructure Grants for States seeking to enhance Medicaid services for people with disabilities who want to work; (3) the Demonstration to Maintain Independence and Employment, which offers Medicaid to workers with potentially disabling conditions; (4) an extension to 8.5 years of Medicare Part A benefits for SSDI beneficiaries who return to work; and (5) automatic reinstatement of Medigap coverage for disabled policyholders entitled to Medicare Part A benefits who provide timely notice of the loss of employer-based group health coverage.

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Topical Index

A

Access 1, 40, 53, 85, 87, 88, 92, 106, 133, 137, 141, 143
Access to Care 137
ACSC 13, 18, 19
Acute care 42, 87
African American Women 129
Aid to Families with Dependent Children (AFDC) 51, 52, 53, 54, 55, 90, 93
Alaskan Natives 105
Alere DayLink 109
Ambulatory care sensitive conditions (ACSC) 13
American Indians 104, 105
American Indians/Alaska Natives 104
Analytic support 106
Asthma 96, 110, 134

B

Behavioral health 87, 88, 91, 103
Beneficiary choice 11
Beneficiary information 1
Benefits 5, 7, 10, 12, 13, 14, 15, 21, 51, 52, 53, 54, 55, 57, 63, 64, 65, 66, 69, 89, 90, 93, 99, 101, 111, 112, 117, 140, 142
Best practices 26, 36, 68, 104, 114, 124
Boren Amendment 34
Building research capacity 123
Buy-in 57, 58, 59, 60, 61, 62, 63, 64, 66, 102

C

Cancer 104, 124, 125, 129, 130, 132, 133, 147
Cancer Screening 129, 132
Cardiovascular 30
Case mix adjustment 31, 155
Child Health 3, 146, 149
Children 1, 51, 52, 53, 54, 56, 72, 73, 86, 87, 91, 93, 98, 103, 104, 128, 134
Chronic disease 18, 99, 105, 111, 115, 139
Clinical outcomes 104
Community-based 3, 5, 68, 69, 70, 71, 89, 101, 103, 104, 108, 119, 132, 133, 134
Consumer choice 63, 69
Continuous quality improvement 6, 49, 113, 116
Contractors 4, 5, 33, 101, 114, 115
Coordinated Care 26, 27, 28, 29, 30
Cost 1, 3, 8, 9, 10, 12, 23, 25, 26, 27, 30, 31, 36, 43, 44, 45, 47, 48, 55, 56, 58, 61, 88, 91, 96, 100, 111, 116, 118, 119, 120, 121, 123, 130, 133, 139, 141, 142
Cost model 58
Costs 47, 128, 129
Coverage 49, 53, 57, 111, 139, 147
Cultural competence 97

D

Data 3, 4, 5, 9, 10, 12, 14, 18, 21, 31, 40, 41, 47, 49, 50, 72, 86, 92, 97, 100, 103, 104, 106, 108, 116, 123, 124, 125, 126, 127, 129, 136, 140, 141, 142, 145, 146, 147, 152, 153, 155
Data base 35, 43, 58, 118, 124
Data management 4
Death 105, 117, 119
Dementia 33
Demonstration 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 35, 36, 37, 38, 39, 40, 44, 45, 48, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 72, 73, 86, 87, 88, 89, 90, 91, 92, 93, 95, 97, 98, 99, 100, 101, 103, 104, 105, 107, 109, 110, 113, 115, 117, 118, 119, 120, 121, 123, 129, 130, 138, 143, 144, 146, 149, 151, 155, 156
Developmental Disabilities 76, 83, 101
Devices 35
Diabetes 9, 10, 23, 25, 26, 29, 103, 104, 105, 106, 107, 111, 115, 118, 128, 131, 150
Disability 60, 64, 99, 103
Disabled 92, 102, 126, 150
Disease management 23, 26, 27, 28, 29, 48, 111, 131
Disenrollment 8
Disparities 99, 104, 105, 106, 131, 133, 136
Drug Coverage 48, 49
Drugs 127
Dual Eligibles 3, 99
Durable Medical Equipment 33, 36, 37, 46

E

Elderly 14, 15, 33, 58, 99, 140
Eligibility........................... 4, 25, 27, 47, 51, 53, 54, 55, 58, 59, 63, 73, 86, 87, 89, 91, 92, 93, 95, 97, 98, 99, 101, 104, 139
Employment 51, 53, 54, 57, 58, 59, 60, 61, 62, 63, 64, 65, 150
Encounter data 11, 12, 18, 19, 118, 138
End of life... 15, 56
End Stage Renal Disease (ESRD) 10, 13, 14, 38, 155
Enrollment.......................2, 3, 11, 12, 14, 15, 17, 36, 44, 49, 51, 56, 58, 72, 73, 86, 94, 95, 96, 100, 101, 102, 104, 105, 106, 118, 120, 121, 124, 125, 126, 136, 155
Environmental Factors 96
Evaluation 1, 2, 3, 4, 6, 10, 11, 12, 13, 15, 18, 20, 23, 25, 26, 31, 33, 34, 35, 40, 45, 46, 48, 55, 65, 86, 88, 92, 93, 94, 95, 96, 99, 101, 111, 112, 119, 148, 149, 150, 155
EverCare 14, 18
Expenditures 3, 19, 20, 21, 24, 27, 33, 34, 47, 48, 49, 52, 53, 54, 55, 56, 89, 92, 97, 102, 103, 106, 123, 150

F

Family planning services 95, 97, 98
Federal Employees Health Benefits Program..........10
Fee for Service 108, 149
FEHBP 10
Food Stamps 54
Frail elderly...27

H

HBCU... 131
Health benefit................................ 46, 58, 117, 119
Health care delivery 26, 47, 86, 90, 91, 117, 119, 138
Health care utilization...................................... 106
Health disparities 104, 105, 131, 136
Health education...........................68, 129, 130, 133
Health expenditures 47
Health Insurance............1, 51, 62, 72, 86, 87, 91, 93, 103, 104, 123, 124, 137
Health Maintenance Organization........ 15, 16, 17, 18, 19, 127, 140
Health Outcome Survey (HOS) 14
Health promotion...................48, 104, 128, 129, 131
Health Services Utilization................................ 132
Healthy aging..47
Healthy People 2010 105
Heart failure.............................23, 27, 29, 32, 107, 109, 111, 118, 119
HEDIS 155
Hispanic Health Services Research 132, 133, 134
Hispanics... 105, 133
Historically Black Colleges and Universities (HBCU) 128, 131
HIV/AIDS 65, 104, 132, 150
Home health.. 122
Home Health Care 32
Hospital...................... 11, 28, 29, 31, 33, 38, 39, 40, 43, 120, 122, 123, 132, 133, 135, 138
Hospital discharge rates.....................................18

I

ICF/MR...34
Information systems 12, 58, 59, 64, 86
Information technology 86
Injuries... 129
Inpatient.................. 1, 4, 13, 15, 18, 21, 22, 30, 32, 43, 90, 97, 106, 113, 116, 118, 123, 138, 148
Insurance......................... 3, 5, 7, 13, 21, 45, 46, 51, 61, 62, 63, 90, 92, 94, 95, 117, 123, 127, 134, 139, 152
Intervention strategies 63, 129, 131, 134
Investigation 13
Ischemic heart disease 105

L

Lock-in 2
Long Term Care........................35, 36, 42, 57, 100, 113, 140, 150, 152
Low income...............................48, 129, 152, 153
Low vision.. 109

M

M+C.............................. 2, 11, 18, 19, 21, 22, 140
Mammography... 130
Managed Care 11, 14, 21, 46, 88, 90, 92, 100, 101, 108, 124, 128, 136, 138, 146, 151, 152
Market area.. 34, 47, 101
Market research..7

MassHealth 73, 94
Medicaid 1, 2, 3, 4, 5, 11, 14, 15, 16, 17, 23, 34, 43, 44, 45, 47, 48, 49, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 69, 70, 71, 72, 73, 74, 79, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 106, 123, 127, 128, 129, 130, 133, 136, 138, 140, 141, 143, 144, 146, 147, 149, 150, 151, 152, 153, 155, 156
Medicaid demonstration 88, 92, 94, 97
Medicaid eligibility 4, 53, 55, 66, 89, 90, 91, 93, 95, 98, 140
Medicaid Statistical Information System (MSIS) 4
Medicare Choices 12, 19
Medicare Current Beneficiary Survey (MCBS) 7, 49, 106, 123, 141, 142, 143
Medicare Health Outcomes Survey 124, 155
Medicare Health Survey 14
Medicare+Choice 2, 5, 6, 7, 8, 9, 11, 12, 14, 16, 17, 18, 21, 46, 100, 111, 118, 140, 141, 146, 156
Medicare+Choice (M+C) 2, 11, 18, 21, 46, 140, 141
Mental health 10, 86, 142
Mental Illness 71, 97
Mexico 47, 62, 91, 132
Minimal Data Set (MDS) 4
Minority health 131
Monitoring 1, 3, 6, 7, 26, 27, 30, 35, 42, 43, 49, 60, 69, 101, 102, 103, 109, 113, 114, 116, 119, 120, 142

N

National Health Accounts 33, 34, 127, 142
National Medicare Education Program (NMEP) 5, 6, 7, 49
Native Americans 133
Nurse 26, 55, 111, 141
Nursing 1, 4, 15, 18, 33, 34, 69, 70, 71, 72, 74, 75, 76, 78, 79, 101, 107, 108, 109, 110, 111, 112, 113, 119, 127, 129, 137, 140, 141
Nursing Facilities 33, 34
Nutrition 20, 35, 37, 68, 91, 111, 129

O

Office of Personnel Management 10
Online Survey Certification and Reporting System (OSCAR) 72, 116
OPM 10
Outcome and Assessment Information Set (OASIS) 4, 31, 72, 114, 116, 122
Outcome measures 14, 25, 69, 118
Outpatient 1, 4, 34, 41, 42, 43, 44, 45, 90, 97, 123, 138
Outpatient rehabilitation 1, 34, 43

P

PACC 56
PACE 14, 15, 22, 149
Paraprofessionals 111
Parity 10, 91
Payment 1, 11, 12, 15, 23, 24, 26, 34, 40, 66, 67, 126, 137, 146, 150, 151
Payment Methods 137
Payment system 1, 9, 23, 31, 33, 35, 41, 43, 47, 66
Peer Review Organization 114, 115, 119, 124
Performance measurement 30, 108, 124
Pneumonia 107, 118
Post acute care 15
Practice expense 23, 42
Preferred Provider Organization (PPO) 31
Pregnant women 91
Prenatal care 106
Prescription Drugs 49, 147
Prevention 103, 104, 125, 130, 134, 147
Program for All-Inclusive Care for the Elderly (PACE) 14, 15
Prospective Payment 31, 33, 34, 41, 42, 43
Prostate Cancer 130
Publication 25, 35, 151, 156
Purchasing 23, 46, 47, 48, 49, 59, 91, 93, 94, 115

Q

Quality 4, 8, 14, 27, 28, 29, 30, 35, 37, 94, 106, 107, 108, 109, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 124, 128, 138, 141, 147, 149, 153, 155

Quality Assurance 14, 113, 155
Quality improvement 9, 14, 31, 72, 94, 101, 107, 108, 113, 114, 115, 155
Quality of Care...........................27, 28, 29, 30, 141
Quality of life.......................... 3, 25, 36, 47, 64, 65, 66, 70, 104, 106, 107, 108, 109, 133, 134, 138, 141
Quality of service 3, 6, 24, 27, 30, 100

R

Racial and Ethnic Adult Disparities in Immunization Initiative.................................103
Ratebook 19
Real Choice 69, 70, 71, 73, 75, 76, 77, 78, 79, 80, 81, 82, 83
Rehabilitation.....................1, 18, 43, 59, 64, 71, 77, 85, 109, 116, 117, 129, 137, 147, 148
Rehabilitation Facilities 116
Report to Congress 3, 17, 34, 147
Risk adjustment................ 11, 14, 18, 19, 20, 21, 99, 100, 112, 117, 140
Risk Adjustment Models............................... 19, 20

S

School attendance...54
Senior Prime 12
Skilled nursing facilities.................9, 34, 35, 42, 110
Special health care needs 93
State Children's Health Insurance Program (SCHIP)........................ 1, 3, 23, 51, 56, 72, 73, 86, 87, 91, 93, 95, 104, 127, 147, 169
State Medicaid Reform Demonstrations.................92
Statistics......................... 41, 49, 118, 123, 125, 127
Substance Abuse 71, 92, 97
Subvention.. 12, 19
Survey 2, 3, 5, 6, 7, 8, 9, 10, 13, 14, 18, 21, 31, 35, 37, 42, 47, 95, 103, 107, 108, 109, 111, 112, 115, 116, 119, 120, 123, 131, 135, 138, 141, 142, 143, 153, 155
Survey and certification.................................... 109
Systems Change Grants for Community Living......72

T

Technology 86, 131
Teen violence...130
Telemedicine...................................23, 25, 26, 133
Two-parent families 51, 52
Ticket to Work and Work Incentives Improvement Act (TWWIIA)...........51, 57, 59, 61 63, 64, 66, 150, 171

U

Uninsured.....................3, 51, 70, 72, 87, 88, 89, 90, 92, 94, 130, 134, 139, 152, 153
Utilization.....................1, 26, 41, 71, 102, 103, 133, 138, 141, 148, 150

V

Vision 44, 45, 109
Vulnerable Populations.......................................99

W

Waiver programs 3
Web...6, 26, 41, 155

Alphabetical Index of Research and Demonstration Projects

A

A Better Chance Welfare Reform Project .... 95-068..........52

A Longitudinal Study of Health Coverage Transitions Between the Years of 59 and 67: The Risk of Being Uninsured and Underinsured .... 02-023........139

A Plan to Address Health Disparities in the African American Communities .... 01-263........104

A Systematic Approach to Improving Pap Smear Screening Rates Among Hispanic/Latina Women in Managed Medicaid Systems .... 00-078........133

Achieving Change For Texans......... 96-044..........52

Active Project Report Annual Production .... 02-074........156

Active Project Report: Reconsideration, Revision, and Production Improvements .... 01-166........151

Activities Prior to the Construction of State Medicaid Research Files (SMRFs) for 1996-1998 .... 00-068...........4

ADP Services Supporting Research, Analysis and Demonstration Activities– Base Contract .... 02-080........155

Age Well Option (now referred to as TLC) .... 97-018..........18

Aging in Place A New Model for Long-Term Care............ 99-068..........27

Ambulatory Care Sensitive Conditions - II .... 00-085..........18

American Indian/Alaska Native Eligibility and Enrollment in Medicaid, the State Children's Health Insurance, and Medicare .... 01-167........103

American Indian/Alaskan Native Consultation on Health Disparities Research .... 01-265........105

Analysis of Large Data Sets Task Order Contract - Acumen .... 01-132........152

Analysis of Large Data Sets Task Order Contract - Anasys .... 01-138........153

Analysis of Large Data Sets Task Order Contract – ARC............ 01-134........152

Analysis of Large Data Sets Task Order Contract – Econometrica .... 01-140........152

Analysis of Large Data Sets Task Order Contract - HER .... 01-133........152

Analysis of Large Data Sets Task Order Contract – JEN .... 01-136........152

Analysis of Large Data Sets Task Order Contract – Jing Xing .... 01-141........153

Analysis of Large Data Sets Task Order Contract – Klemm .... 01-139........153

Analysis of Large Data Sets Task Order Contract – McDonald .... 01-135........152

Analysis of Large Data Sets Task Order Contract – QRS .... 01-137........153

Analysis of Medicare Beneficiary Baseline Knowledge Data Using MCBS .... 99-035..........49

Analysis of Medicare Current Beneficiary Survey (MCBS) Data Phase III .... 01-216........ 142

Analysis of State Medicaid Program Experience with Assertive Community Treatment (ACT) Programs for Persons with Mental Illness .... 99-100..........97

ARKids B .... 98-201..........89

Arizona Health Care Cost Containment System .... 82-001..........87

Arizona Welfare Reform: Employing and Moving People Off Welfare and Encouraging Responsibility Program .... 95-047..........53

Assertive Community Treatment (ACT) and other Community-Based Services for Persons with Mental Illness or Persons with Co-Occurring Mental Illness and Substance Abuse Disorders .... 02-072..........71

Assess the Impact of Requiring Parity for Mental Health .... 00-031..........10

Assessing the Impact of a Comprehensive School-Based Health, Educational, and Social Services Program for Pregnant Adolescents on Their Pregnancy Outcomes and the Health of Their Children ..... 99-073........ 128

Assessment of Medicare & You Education Program .... 01-115...........5

Assessment of Medicare Prescription Drugs and Coverage Policies .... 00-115..........49

Assessment of State Database Capacity and Development of Prototype Performance Monitoring System .... 01-215........ 102

Assessment, Refinement and Analysis of the Existing Prospective Payment System for Skilled Nursing Facilities .... 01-108..........34

Asthma Champion Initiative........... 01-267........ 110

B

Behavior Validation to Decrease Problem Behaviors of Elderly with Advanced Dementia .... 00-090..........33

C

Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project .... 01-151........ 104

Caregiving from the Care Recipient Perspective: Influence of Caregiving on Health and Use of Health Services .... 02-029........ 141

Case Studies of Managed Care Arrangements for Dual Eligible Beneficiaries .... 99-041........ 101

Case-Mix Adjustment for a National Home Health Prospective Payment System .... 96-057..........31

Cash and Counseling Demonstration: Florida's "Consumer-Directed Care Program" .... 99-012..........96

Cervical and Breast Cancer Screening for Post-Reproductive Age Hispanic Women Residing Near the U.S.-Mexico Border .... 99-072........ 132

Clinical and Economic Effectiveness of a Technology-Driven Heart Failure Monitoring System .... 00-065........ 109

Colorado Transition Project .... 01-162..........78

Community Health Advocate Program .... 00-040..........68

Community-Integrated Personal Assistance Services and Supports - Alaska .... 01-181..........84

Community-Integrated Personal Assistance Services and Supports - Arkansas .... 01-193..........84

Community-Integrated Personal Assistance Services and Supports - Guam 01-183 84

Community-Integrated Personal Assistance Services and Supports – Michigan 01-185 84

Community-Integrated Personal Assistance Services and Supports - Minnesota 01-186 84

Community-Integrated Personal Assistance Services and Supports - Montana 01-188 85

Community-Integrated Personal Assistance Services and Supports - Nevada 01-190 85

Community-Integrated Personal Assistance Services and Supports - New Hampshire 01-189 85

Community-Integrated Personal Assistance Services and Supports - Oklahoma 01-191 85

Community-Integrated Personal Assistance Services and Supports - Rhode Island 01-192 85

Construction of Analytic Files for Study of the Cardiac Rehabilitation Benefit Among Medicare Beneficiaries 02-081 117

Consultation and Assistance with Evaluation of the Medigap Monitoring Demonstration Grants 01-279 45

Consumer Directed Durable Medical Equipment Demonstration for Beneficiaries with Disabilities 00-051 37

Consumer Directed Durable Medical Equipment Demonstration Project 00-050 36

Consumer Directed Durable Medical Equipment Demonstration for People with Physical Disabilities 00-052 37

Consumer Driven Durable Medical Equipment Acquisition Program 00-049 37

Continuing Care Network Demonstration 99-114 101

Continuing Care Network Demonstration, Technical Assistance and Third Party Assessments 99-115 100

Conversion of Medicaid Statistical Information System to a DB2 Database 01-273 127

Convert CMS Research Results to Consistent Standardized Architecture to Support Web-Based Dissemination (with two Options) 02-075 156

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Arizona 01-030 30

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Baltimore, Maryland 01-035 29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Florida 01-032 28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Houston, Texas 01-037 29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Iowa 01-033 29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Mahomet, Illinois 01-029 28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Maine .... 01-028..........28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Massachusetts .... 01-034..........29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – New York, NY .... 01-039..........29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Northern California .... 01-038..........30

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Pennsylvania .... 01-040..........28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Richmond, Virginia .... 01-031..........28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – South Dakota .... 01-041..........28

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – University of Maryland .... 01-036..........29

Coordinated Care to Improve Quality of Care for Chronically Ill Medicare Beneficiaries – Washington, DC ..... 01-042..........28

Costs for Providing Health Care to Undocumented Persons .... 01-148..........47

D

Data Collection for Second Generation SHMO .... 97-210..........18

Data Collection to Support Policy Analysis of Choices Offered to Medicare+Choice Enrollees and Choices Made by Enrollees .... 00-123..........21

Data from National Rx Audit Databases - II .... 01-248........126

Decisionmaking in Managed Care Organizations .... 98-234..........21

Demonstration Project for Family Planning and Preventive Reproductive Services, State of Maryland .... 96-004..........98

Demonstration Project to Establish an Independent Investigative Unit for Deaths and Abuse of the Disabled .... 01-262........102

Department of Defense Subvention Demonstration Evaluation .... 98-236..........12

Describing and Assessing the Implication of Developing and Implementing a Prospective Payment System for Long Term Care Hospitals .... 99-034..........42

Descriptive Statistical Data on Health Maintenance Organizations .... 01-276........127

Design and Conduct of Survey Task Order Contracts - Abt .... 01-123........154

Design and Conduct of Survey Task Order Contracts - AIR .... 01-125........154

Design and Conduct of Survey Task Order Contracts - Analytical Sci .... 01-131........153

Design and Conduct of Survey Task Order Contracts – Anasys .... 01-128........154

Design and Conduct of Survey Task Order Contracts - Gallup .... 01-124........ 153

Design and Conduct of Survey Task Order Contracts - HER .... 01-129........ 154

Design and Conduct of Survey Task Order Contracts – Hope .... 01-119........ 153

Design and Conduct of Survey Task Order Contracts - Jing Xing..... 01-130........ 154

Design and Conduct of Survey Task Order Contracts – MPR .... 01-127........ 154

Design and Conduct of Survey Task Order Contracts - NORC .... 01-121........ 154

Design and Conduct of Survey Task Order Contracts - RAND .... 01-126........ 154

Design and Conduct of Survey Task Order Contracts - RTI .... 01-120........ 154

Design and Conduct of Survey Task Order Contracts - Westat .... 01-122........ 154

Design and Implementation of a Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries .... 02-079............1

Design and Implementation of Medicare Home Health Quality Assurance Demonstration ... 94-074........ 113

Design and Simulation of Alternative Medigap Structure .... 99-048..........45

Design and Test of Evidence-Based Communications Strategies to Increase Consumer Awareness and Understanding of Long-Term Care Options................................ 00-066............5

Design, Development, and Implementation of an Improved Medicare Outpatient End Stage Renal Disease Prospective Payment System .... 00-116..........41

Design, Development, Implementation, Monitoring & Refinement of a Prospective Payment System for Inpatient Rehabilitation .... 99-038..........43

Determinants of Influenza Vaccination Timing .... 01-050........ 139

Develop, Conduct and Analyze Surveys of Quality Improvement Organization (QIO) Customers........ 02-078........ 111

Developing and Evaluating the Use of a Quality Indicator Format in the End Stage Renal Disease Survey Process .... 99-081..........37

Development and Evaluation of Medical Intervention for Early Childhood Caries .... 02-031..........55

Development and Production of the Medicare Quality Monitoring System .... 00-122........ 107

Development and Validation of a Performance Measure Set for the Evaluation of Medicaid Services Rendered to People with Developmental Disabilities .... 99-056........ 101

Development and Validation of Measures and Indicators of the Quality Appropriateness of Services Rendered in Post-Acute and Long Term Care Settings .... 98-257........ 113

Development of Databases, Data Processing, Data Analysis and Table Construction for Skilled Nursing Facility Refinement Project .... 00-029............9

Development of Quality Indicators for Inpatient Rehabilitation Facilities .... 01-170........ 116

Diabetes Factors Influencing Self-Care Among African Americans in Rural and Urban Populations .... 01-243........ 131

Diabetes Care Across the Life Span for Medicaid Beneficiaries: Gender and Racial Differences .... 00-174........ 103

Direct and Indirect Effects of the Changes in Home Health Policy and an Analysis of the Skill Mix of Medicare Home Health Services Before and After the Balanced Budget Act of 1997 .... 00-023..........31

Disabled and Special Needs Populations Examining Enrollment, Utilization and Expenditures .... 00-131........ 102

E

Econometric Forecasting and Economic Services - II .... 01-240........ 126

Economic and Cost-Effectiveness Studies for the U.S. Renal Data System .... 93-061...........9

Effect of Payment Methods on Rehabilitation Care in Nursing Homes .... 01-045........ 137

Effects of Health Care Provider Affiliations on Patient Treatment and Outcomes .... 01-049........ 138

Effects of State Medicaid Policies on Elderly Persons' Savings Patterns and Long Term Care .... 02-024........ 140

Efficacy of a Culturally Sensitive Health Promotion Program To Improve Exercise and Dietary Behaviors in African American Elders with Hypertension .... 00-075........ 128

End Stage Renal Disease (ESRD) Managed Care Demonstration Health Options .... 96-083..........14

Environmental Factors that Increase the Risk of Asthma in Medicaid Recipients ...... 01-280..........96

Environmental Scan for Selective Contracting Practices with Efficient (Qualified) Physicians and Physician Group Practices; Profiling Techniques; Incentive Payments and Barriers to Selective Contracting 24

Capitation Demonstration, Evaluation .... 97-022..........13

Evaluating Health System Performance Access and Quality of Care for Acute Cardiac Events in the Rural Medicare Population .... 02-028........ 141

Evaluating the Use of Quality Indicators in the Long Term Care (LTC) Survey Process .... 98-252..........35

Evaluation of Balanced Budget Amendment (BBA) Impacts on Medicare Delivery and Utilization of Inpatient and Outpatient Rehabilitation Therapy Services .... 01-114............1

Evaluation of Community Nursing Organization (CNO) Demonstrations, Phase II .... 00-064..........20

Evaluation of Competitive Bidding Demonstration for DME and POS .... 98-239..........35

Evaluation of Group-Specific Volume Performance Standards Demonstration .... 96-081..........25

Evaluation of Independent Informal Dispute Resolution Process (IDR) .... 00-175........ 112

Evaluation of Issues Related to Prospective Payment System under Consolidated Bidding for Skilled Nursing Facilities and Home Health Agencies 99-057 33

Evaluation of Medicaid Family Planning Demonstrations 02-073 95

Evaluation of New Jersey Hospital Association Demonstration of Performance Based Incentives 99-036 11

Evaluation of Private Fee-for-Service Plans in the Medicare+Choice Program 01-144 2

Evaluation of Programs of Coordinated Care and Disease Management 00-113 26

Evaluation of Programs of Disease Management (Phase I and Phase II) 02-064 23

Evaluation of the BadgerCare Medicaid Demonstration 00-132 95

Evaluation of the Demonstration to Maintain Independence and Employment (DMIE) and Other Related Disease-Specific 1115 Waiver Programs 01-113 65

Evaluation of the Development and Early Implementation of Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative 02-068 86

Evaluation of the Dialysis Facility Compare Website 02-053 155

Evaluation of the Diamond State Health Plan 95-028 93

Evaluation of the Evercare Demonstration Program 97-216 18

Evaluation of the Illinois State Pharmacy Assistance Program 02-076 10

Evaluation of the Impact on Beneficiaries of the Medicare+Choice Lock-in Provision 01-116 2

Evaluation of the Informatics, Telemedicine, and Education Demonstration 00-117 25

Evaluation of the MassHealth Quality Improvement Plan and Insurance Reimbursement Program 99-071 94

Evaluation of the Medical Savings Account Demonstration 98-237 12

Evaluation of the Medicare Preferred Provider Organization (PPO) Demonstration (Phase I and Phase II) 02-051 31

Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions 99-054 40

Evaluation of the Ohio Behavioral Health Program 97-024 88

Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) as a Permanent Program and of a For-Profit Demonstration 01-214 15

Evaluation of the Qualified Medicare Beneficiary (QMB) and the Specified Low-Income Medicare Beneficiary (SLMB) Programs 99-052 2

Evaluation of the State Child Health Insurance Program 99-069 3

Evaluation of the State Medicaid Reform Demonstrations, II 95-052 92

CMS

Evaluation of Wheel Chair Purchasing in the Consumer-Directed Durable Medical Equipment (CD-DME) Demonstration and Other Fee-For-Service and Managed Care Settings .... 02-063..........46

Evidence Report on Routine Thyroid Screening .... 01-259........112

Examining Gender and Racial Disparities Among Medicare Beneficiaries with Chronic Diseases........................... 00-092........105

Examining Long-Term Care Episodes and Care History for Medicare Beneficiaries .... 02-056........117

Expanded Evaluation of Medicare&You Handbook 2000 .... 99-028............6

Expansion of Special Policy Analysis Model (SPAM) - II .... 97-025........124

Extension of Medicaid Benefits for Post-Partum Women .... 94-105..........97

F

Feasibility Study to Improve the Detection and Prevention of Duplicate and Near Duplicate Claims .... 96-221........125

G

Grants Writing Workshop for Hispanic Researchers - II .... 01-252........135

Grants Writing Workshop for Historically Black Colleges and Universities' Researchers – II .... 01-251........131

H

Hawaii QUEST .... 93-062..........91

HBCU's Health Services Research Network Strategic Planning Workshop – Improving Health Outcomes and Minimizing Health Disparities in the African American Population .... 01-255........131

HCFA On-Line: Market Research for Beneficiaries – I .... 96-080............6

HCFA On-Line: Market Research for Beneficiaries – II .... 99-063............7

Health Disparities: Longitudinal Study of Ischemic Heart Disease Among Aged Medicare Beneficiaries .... 00-069........105

Health Disparities: Measuring Health Care Use and Access for Racial/Ethnic Populations.................................. 02-054.......106

Health Disparities in the Hispanic American Community: Analysis, Recommendations, and Strategies............................... 01-256........135

Health Loop Information Project .... 00-126..........68

Health Passport Project .... 01-169..........86

Health Promotion in the African American Community: A Computer-Based Nutrition Program .... 00-072........129

Health Status and Quality of Life for Women with Diabetes: Data from the Medicare Current Beneficiary Survey .... 00-121........106

Health Technology Improvement: Testing the Acceptability of Using Electronic Data Interchange Among Traditional and Safety Net Providers in Los Angeles County .... 01-117..........86

HealthChoice: The Impact of Mandated Managed Care on Emergency Department Utilization in the State of Maryland .... 01-047........138

Healthy Aging: Senior Risk Reduction Program .... 02-065..........48

Healthy Aging/Smoking Cessation .... 01-217........118

Healthy Aging/Smoking Cessation .... 98-276........117

Healthy Maine .... 01-254..........70

Heart Failure Home Care .... 01-220........119

Hispanic Health Services Utilization: Defining and Exploring Disparities .... 99-078........132

Hispanic Technical Assistance Workshop on Accessing, Utilizing, and Understanding HCFA's Medicare/Medicaid Data for Hispanic American Health Professionals/Researchers – Mid Atlantic Region...................... 136

Home & Community-based Services Study .... 98-224............3

Home Health Data Link .... 01-210............4

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI Pilot PRO – Maryland .... 00-013........114

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI Pilot PRO – Michigan .... 00-015........115

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI Pilot PRO – New York .... 00-014........114

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI Pilot PRO – Rhode Island .... 00-016........115

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI Pilot PRO – Virginia .... 00-017........115

Home Health Outcome Based Quality Improvement System Pilot Demonstration – HH OBQI System PRO .... 00-012........114

Hospital Cost Monitoring .... 97-014........123

Hospital Outpatient Prospective Payment System Development of Volume Performance Standards and a Hospital Outpatient Market Basket .... 99-062..........43

How Do Variations in Treatment of Ductal Carcinoma In Situ (DCIS) Affect Outcomes .... 01-043........136

I

Identification of Risk Factors, Barriers, and Severity for Emergency Room Asthma in Puerto Rico.......... 00-079........134

Impact of Managed Care upon Medicaid Women and Newborns .... 00-008........136

Impact of Nonresponse of MCBS Estimates .... 01-246........143

Impact of Welfare Reform on Medicaid Populations .... 98-235..........53

Implementation of Consumer Assessments of Health Plans Disenrollment Survey .... 99-080............8

Implementation of Quality Improvement Organization 6th Scope of Work Pneumococcal Pneumonia and Influenza Immunization Remeasurement Survey .... 00-120........ 119

Implementation of the Medicare Consumer Assessment of Health Plans Survey........ 97-265........ 8

Implementation of the READII Survey .... 02-062........ 103

Implementation Support for the Medicare Coordinated Care Demonstration .... 00-082........ 27

Implementation Support for the Medicare Participating Centers of Excellence Demonstration .... 01-222........ 30

Implementing the HEDIS© Medicare Health Outcomes Survey .... 98-277........ 155

Improved Protocols for Home Health Agency Assessment in the Survey Process .... 01-118........ 115

Improving Managed Care Outcomes Using Medicare Health Outcomes Survey Data .... 99-094........ 124

Improving Medication Safety in Outpatients Through Improved Packaging .... 01-212........ 110

Improving Nursing Home Enforcement .... 01-171........ 109

Improving the Consistency of the Nursing Home Survey Process .... 02-058........ 10

Incontinence Morbidity, Adjustment to Illness, and Quality of Life after Prostatectomy .... 01-048........ 138

Increasing Access to Health Care for Buck's County Residents .... 01-150........ 85

Increasing Breast Cancer Screening in African American Women: A Community Pilot Project .... 00-073........ 129

Increasing Mammography Screening Among African American Females in Rural Areas: An Educational Intervention Program .... 01-245........ 130

Influenza and Pneumococcal Analytic Reports .... 96-050........ 118

Informatics, Telemedicine, and Education Demonstration .... 00-166........ 25

Innovations in Health Care .... 01-264........ 110

Innovative Management of Dental Decay for Young Children Enrolled in Medicaid and/or the State Children's Health Insurance Program (SCHIP) .... 02-032........ 56

Integrated Chronic Disease Quality Performance Measurement at the Physician Level........ 01-211........ 115

Integrated Payment Option Support Contract .... 02-052........ 15

Intergenerational HIV Prevention Intervention for Latina Women .... 00-076........ 134

International Comparative Data and Analysis of Health Care Financing and Delivery Systems - II .... 00-048........ 125

Investigation of Increasing Rates of Hospitalization for Ambulatory Care Sensitive Conditions among Medicare Beneficiaries .... 02-055........ 13

Iowa Senior Discount Prescription Drug Demonstration Project .... 01-053........ 48

K

Kentucky Health Care Partnership Plan Amendment .... 94-128..........87

L

Lessons Learned from State Medicaid and Pharmacy Assistance Programs .... 01-258..........48

Logistics for Systems Change Grants for Community Living (SCGCL) and SCGCL Conference .... 01-269..........72

Long-Term Job Lock Revisited: Estimating the Effect of Federal Health Insurance Portability Legislation on Job Transitions for Sick Individuals, 1996-1999 .... 01-046........137

M

Maintain Independence and Employment Demonstration – District of Columbia .... 02-002..........65

Maintain Independence and Employment Demonstration – Mississippi .... 01-002..........65

Maintain Independence and Employment Demonstration – Rhode Island .... 01-001..........65

Maintain Independence and Employment Demonstration – Texas .... 02-001..........65

Maintain Independence and Employment Program – Infrastructure Grant – Alabama .... 01-011..........57

Maintain Independence and Employment Program – Infrastructure Grant – Alaska .... 01-017..........57

Maintain Independence and Employment Program – Infrastructure Grant – California .... 02-019..........57

Maintain Independence and Employment Program – Infrastructure Grant – Colorado .... 02-007..........57

Maintain Independence and Employment Program – Infrastructure Grant – Connecticut .... 01-018..........58

Maintain Independence and Employment Program – Infrastructure Grant – Delaware ` .... 02-008..........58

Maintain Independence and Employment Program – Infrastructure Grant – District of Columbia .... 01-027..........58

Maintain Independence and Employment Program – Infrastructure Grant – Georgia .... 01-026..........58

Maintain Independence and Employment Program – Infrastructure Grant – Idaho .... 01-022..........59

Maintain Independence and Employment Program – Infrastructure Grant – Illinois .... 01-025..........59

Maintain Independence and Employment Program – I nfrastructure Grant – Illinois .... 02-010..........59

Maintain Independence and Employment Program – Infrastructure Grant – Kansas .... 01-013..........59

Maintain Independence and Employment Program – Infrastructure Grant – Louisiana .... 02-012..........60

Maintain Independence and Employment Program – Infrastructure Grant – Maine.. 01-010..........60

Maintain Independence and Employment Program – Infrastructure Grant – Massachusetts .... 01-021..........60

Maintain Independence and Employment Program – Infrastructure Grant – Minnesota.................................. 01-015..........60

Maintain Independence and Employment Program – Infrastructure Grant – Nebraska .... 01-008..........60

Maintain Independence and Employment Program – Infrastructure Grant – Nebraska .... 02-006..........61

Maintain Independence and Employment Program – Infrastructure Grant – Nevada .... 01-020..........61

Maintain Independence and Employment Program – Infrastructure Grant – New Hampshire .... 01-004..........61

Maintain Independence and Employment Program – Infrastructure Grant – New Jersey .... 01-006..........61

Maintain Independence and Employment Program – Infrastructure Grant – New Mexico .... 01-009..........62

Maintain Independence and Employment Program – Infrastructure Grant – New York .... 02-015..........62

Maintain Independence and Employment Program – Infrastructure Grant – North Dakota .... 02-018..........62

Maintain Independence and Employment Program – Infrastructure Grant – Ohio .... 02-003..........62

Maintain Independence and Employment Program – Infrastructure Grant – Oklahoma.................................. 02-004..........62

Maintain Independence and Employment Program – Infrastructure Grant – Oregon .... 01-007..........62

Maintain Independence and Employment Program – Infrastructure Grant – Pennsylvania.............................. 02-009..........63

Maintain Independence and Employment Program – Infrastructure Grant – Rhode Island .... 01-016..........63

Maintain Independence and Employment Program – Infrastructure Grant – South Dakota .... 02-011..........63

Maintain Independence and Employment Program – Infrastructure Grant – Texas .... 02-013..........63

Maintain Independence and Employment Program – Infrastructure Grant – Utah .... 01-005..........63

Maintain Independence and Employment Program – Infrastructure Grant – Virginia .... 02-005..........64

Maintain Independence and Employment Program – Infrastructure Grant – Washington .... 01-019..........64

Maintain Independence and Employment Program – Infrastructure Grant – West Virginia .... 01-003..........64

Maintain Independence and Employment Program – Infrastructure Grant – Wyoming .... 02-017..........64

Market Area Selection Criteria and Data Development for Medicare Fee-for-Service Reform 01-213 47

Maryland Medicaid Section 1115 Health Care Reform Demonstration Proposal – HealthChoice 96-009 88

Massachusetts Welfare Reform, 1995 .... 95-069 54

MassHealth Massachusetts Health Reform Demonstration 95-024 94

MassHealth Member Express Renewal 00-101 73

Mauli Ola (Spirit of Life) Project 00-083 68

Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes 94-087 32

Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine 95-023 26

Measurable Outcomes of Nursing Home Initiative 00-105 72

Measurement, Indicators, and Improvement of the Quality of Life in Nursing Homes 98-251 107

Medicaid Buy-In Outcomes Work Incentives Systems – Ticket to Work and Work Incentives Improvement Act 02-069 66

Medicaid Demonstration Project for Los Angeles County 96-007 90

Medicaid Managed Care Quality and Costs Among Black and White Adults with Diabetes Mellitus 99-074 128

Medicaid Payment Accuracy Measurement Project 01-143 66

Medicaid Payment Accuracy Review Project - Louisiana 01-224 67

Medicaid Payment Accuracy Review Project – Minnesota 01-225 67

Medicaid Payment Accuracy Review Project – Mississippi 01-226 67

Medicaid Payment Accuracy Review Project - New York 01-227 67

Medicaid Payment Accuracy Review Project - North Carolina 01-228 67

Medicaid Payment Accuracy Review Project - North Dakota 01-229 67

Medicaid Payment Accuracy Review Project – Texas 01-230 67

Medicaid Payment Accuracy Review Project – Washington 01-231 67

Medicaid Payment Accuracy Review Project - Wyoming 01-232 67

Medicaid Prescription Drug Data 00-124 3

Medicaid/SCHIP Eligibility Pilot: Assisting the Young Uninsured in Daycare Organizations (AYUDO) 00-100 73

Medicaid/SCHIP Eligibility Pilot: Cuyahoga County Income Self-Declaration Pilot 00-104 73

Medicare Behavioral Health Cost and Use Study 01-142 103

Medicare Choices Demonstration Verification of Encounter Data 97-030 12

Medicare Clinical Laboratories Competitive Bidding Demonstration Planning and Technical Assistance 98-256 24

Medicare Competitive Bidding Demonstration for Durable Medical Equipment, II 01-286 37

Medicare Current Beneficiary Survey - II 99-116 142

Medicare Health Maintenance Organizations Withdrawals and Modifications 02-025 140

Medicare Health Outcomes Survey Applied Research Center 99-140 155

Medicare Lifestyle Modification Program Demonstration - Mind/Body Medical Institute – Boston 01-237 121

Medicare Lifestyle Modification Program Demonstration – Mind/Body Medical Institute – Houston 02-021 122

Medicare Lifestyle Modification Program Demonstration – Mind/Body Medical Institute - Nashville 02-020 122

Medicare Lifestyle Modification Program Demonstration – Mind/Body Medical Institute - South Bend 01-239 122

Medicare Lifestyle Modification Program Demonstration – Mind/Body Medical Institute – Warwick, RI 01-238 121

Medicare Lifestyle Modification Program Demonstration – Preventive Medicine Research Institute – Bloomington, IN 01-235 121

Medicare Lifestyle Modification Program Demonstration – Preventive Medicine Research Institute – Kearney, NE 01-236 120

Medicare Lifestyle Modification Program Demonstration – Preventive Medicine Research Institute - Omaha 00-176 121

Medicare Lifestyle Modification Program Demonstration – Preventive Medicine Research Institute - Pittsburgh 00-177 121

Medicare Lifestyle Modification Program Demonstration – Preventive Medicine Research Institute – Rockford, IL 00-178 121

Medicare Lifestyle Modification Program Demonstration Continuous Quality Monitoring 99-136 120

Medicare Lifestyle Modification Program Demonstration Evaluation 00-053 119

Medicare Post-Acute Care Evaluation of Balanced Budget Act Payment Policies and Related Changes 00-067 34

Medicare State Health Profile 96-219 118

Medicare/DoD Subvention Demonstration - Validation of Payment Reconciliation 01-285 12

Medication Analysis in Mexican American Aged 01-146 135

Meeting Support Arrangements 99-147 127

Minnesota Prepaid Medical Assistance Project Assistance Plus (PMAP+) 95-029 93

Minority Health Asian American Research 01-288 105

Missouri Managed Care Plus (MC+) 98-273 92

Montana Welfare Reform Families Achieving Independence in Montana (FAIM) 95-049 51

Moving Towards Elimination of Lead Poisoning in High Risk Children .... 00-125.........98

Multi-State Dual Eligible Data Base and Analysis Development...... 98-202........100

Multi-State Evaluation of Dual Eligibles Demonstrations .... 97-218..........99

Municipal Health Services Program
- Baltimore .... 97-201.........43
- Cincinnati .... 97-204.........44
- Milwaukee .... 97-203.........44
- San Jose .... 97-202.........45

N

National Implementation of Medicare Consumer Assessment of Health Plans Study - Fee-for-Service (CAHPS-FFS) Survey .... 00-043...........8

National Initiative for a Long-term Care Workforce of Paraprofessionals .... 01-257........111

National Resource Center on Home and Community Based Services - Quality Under Home and Community Based Waiver .... 99-121........108

National Technical Assistance Exchange for Community Living - Independent Living Research Utilization .... 01-274.........71

National Technical Assistance Exchange for Community Living - Rutgers .... 01-275.........71

Nebraska Welfare Reform Demonstration Project............ 95-062.........55

New Hampshire Employment Program and Family Assistance Program .... 96-047.........53

New Jersey Cash and Counseling Demonstration .... 99-013.........96

New Jersey Managed Charity Care 9............ 8-272 90

New Mexico Health Care Reform Demonstration .... 99-134.........91

New York Cash and Counseling Demonstration: "Personal Preference Program" .... 99-014.........96

New York Graduate Medical Education Demonstration
- Bronx-Lebanon Hospital Center .. 97-240.........40
- Harlem Hospital Center............ 97-256.........38
- Jacobi Medical Center & North Central Bronx Hospital Joint Project .... 97-252.........39
- Lincoln Medical and Mental Health Center .... 97-239.........40
- Maimonides Medical, Coney Island Hospital & Interfaith Medical Center Joint Project............ 97-253.........39
- Metropolitan Hospital Center .... 97-260.........38
- Mount Sinai Consortium .... 97-250.........39
- New York Eye and Ear Infirmary .... 97-261.........38
- New York University Consortium .... 97-251.........40
- Westchester Medical Center, Sound Shore Medical Center & Mount Vernon Hospital Joint Project .... 97-254.........38
- Woodhull Medical and Mental Health Center .... 97-232.........38

Next Generation Medicare Managed Care Payment System .... 00-110.........11

Northern New England Vascular Surgery Quality Improvement Initiative - I .... 01-221........112

Northern New England Vascular Surgery Quality Improvement Initiative - II .... 01-289........116

Nursing Facility Transition Grant – Arkansas............ 02-046.........74

Nursing Facility Transition Grant – Delaware: Passport to Independence Program .... 02-039..........74

Nursing Facility Transition Grant – Nebraska: Creating Systems Change in the Transition Process Nebraska .... 02-037..........74

Nursing Facility Transition Grant - New Jersey: Young Adult Nursing Facility Resident Transition Initiative...................................... 02-041..........74

Nursing Facility Transition Grant - North Carolina: Nursing Facility Transition Program .... 02-050..........74

Nursing Facility Transition Grant - Rhode Island: Transition to Independence .... 02-049..........74

Nursing Facility Transition Grants - Alabama .... 02-042..........74

Nursing Facility Transition Grants - South Carolina .... 02-040..........73

Nursing Facility Transitions – Independent Living Partnership – Alabama .... 01-199..........75

Nursing Facility Transitions – Independent Living Partnership – Georgia .... 01-200..........76

Nursing Facility Transitions – Independent Living Partnership – Wisconsin .... 01-202..........76

Nursing Facility Transitions – Independent Living Partnership – Texas... 01-201..........76

Nursing Facility Transitions – State Program Grant – Alaska .... 01-157..........78

Nursing Facility Transitions – State Program Grant – Connecticut .... 01-178..........78

Nursing Facility Transitions – State Program Grant – Georgia .... 01-158..........78

Nursing Facility Transitions – State Program Grant – Indiana .... 01-165..........75

Nursing Facility Transitions – State Program Grant – Maryland.................................... 01-159..........78

Nursing Facility Transitions – State Program Grant – Massachusetts .... 01-164..........75

Nursing Facility Transitions – State Program Grant – Michigan .... 01-176..........79

Nursing Facility Transitions – State Program Grant – New Hampshire .... 01-195..........79

Nursing Facility Transitions – State Program Grant – Washington .... 01-196..........74

Nursing Facility Transitions – State Program Grant – West Virginia .... 01-197..........79

Nursing Home Transition 2000 Program Grant: Partnership for Community Living .... 00-130..........70

Nursing Home Transition Grant - Arkansas Passages .... 00-129..........70

Nursing Home Transition Initiative - New Hampshire .... 99-097..........69

O

Oklahoma SoonerCare Demonstration .... 96-008..........93

Oregon Reform Demonstration .... 93-038..........89

Outcome and Assessment Information Set (OASIS) Technical Analysis & Support Contract .... 02-057........122

P

Payment Development, Implementation, and Monitoring Support for the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management Demonstrations 02-066 23

Pennsylvania Nursing Home Transition Grant 2000 .... 00-127 69

Performance Assessment of Web Sites 98-255 6

Pilot Test and Analysis of the Medicare Health Survey for Program for All-Inclusive Care for the Elderly (PACE) and EverCare (MHSPE) 01-168 14

Practice Expense Methodology 99-032 42

Preparation of Analytic Data for the National, State, and Age Health Accounts Data Analysis 01-261 126

Prescription Drug Coverage in Medicaid Using Medicaid Claims Data to Develop Prescription Drug Monitoring and Analysis 02-077 49

Prescription-Filling Problems in the Medicare Population 01-044 137

Program of All-Inclusive Care for Children - Florida 00-098 56

Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance 96-056 14

Programming and Data Base Support for Examining Physician Opt-out Access Issues 99-030 40

Programming Support for Development of the Surveillance, Epidemiology, and End Results (SEER)-Medicare Database 99-060 124

Programming Support for Studies of the Medicare Disabled Population 01-234 126

Programming Support for the Development of the Surveillance, Epidemiology, and End Results (SEER)-Medicare Database to Examine the Hospice Benefit among Aged Medicare Beneficiaries 99-061 125

Q

Quality Monitoring for the Medicare Participating Center of Excellence Demonstration 01-112 30

R

Racial Disparities in Health Services Among Medicaid Pregnant Women, (Multi-State) Analysis 00-093 106

Randomized Controlled Trial of Primary and Consumer-Directed Care for Persons with Chronic Illnesses 94-131 36

Rationalize Graduate Medical Education Funding 00-022 40

Real Choice Systems Change 76, 77

Real Choice Systems Change Grant - Alabama 01-155 79

Real Choice Systems Change Grant - Arkansas 01-163 79

Real Choice Systems Change Grant – Delaware 01-173 80

Real Choice Systems Change Grant – Florida 01-161 80

Real Choice Systems Change Grant - Guam 01-152 80

Real Choice Systems Change Grant - Hawaii 01-153 80

Real Choice Systems Change
Grant - Idaho .... 01-160..........80

Real Choice Systems Change
Grant - Illinois .... 01-154..........80

Real Choice Systems Change
Grant - Kentucky .... 01-194..........80

Real Choice Systems Change
Grant - Maine .... 01-204..........81

Real Choice Systems Change
Grant - Maryland .... 01-187..........81

Real Choice Systems Change
Grant - Massachusetts .... 01-205..........81

Real Choice Systems Change
Grant - Michigan .... 01-206..........81

Real Choice Systems Change
Grant - Minnesota .... 01-208..........81

Real Choice Systems Change
Grant - Missouri .... 01-209..........82

Real Choice Systems Change
Grant - Nebraska .... 01-207..........82

Real Choice Systems Change
Grant - New Hampshire .... 01-203..........82

Real Choice Systems Change
Grant - New Jersey........................ 01-182..........82

Real Choice Systems Change
Grant - North Carolina.................... 01-175..........82

Real Choice Systems Change
Grant – Oregon .... 01-184..........83

Real Choice Systems Change
Grant - South Carolina.................... 01-177..........83

Real Choice Systems Change
Grant - Tennessee .... 01-179..........83

Real Choice Systems Change
Grant - Vermont .... 01-180..........83

Real Choice Systems Change
Grant - Virginia .... 01-156..........83

Rebasing Prospective Payment
System and Exempt Hospital
& Skilled Nursing Facility
Input Price Indices from
Newly Available Sources .... 97-005..........33

Reducing Hospitalization
and Rehabilitation Medicaid
Costs in African American
Teens with Spinal Cord Injuries
Who Survive Teen Violence .... 00-074........129

Refinement of Risk
Adjustment for Special
Populations .... 02-082..........21

Refinements to Medicare
Diagnostic Cost Group
(DCG) Risk Adjustment Models ..... 02-060..........19

Refinements to Medicare
Diagnostic Cost Group Risk
Adjustment Models .... 96-211..........19

Research and Analytic
Support for Implementing
Performance Measurement
in Fee-for-Service .... 97-264........108

Research and Demonstrations
Projects Searchable Database
Stage Two, Improvement,
Enhancements, and
Implementation .... 01-145........143

Research on System
Change for Community
Living... 01-172..........75

Research, Analysis,
Demonstration, and Survey
Task Order Contract –
Medicaid Research and
Demonstrations - Abt .... 00-161........151

Research, Analysis,
Demonstration, and Survey
Task Order Contract –
Medicaid Research and
Demonstrations - C.N.A. .... 00-165........150

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - CHPR .... 00-164........ 151

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - HER .... 00-158........ 150

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - Lewin .... 00-163........ 150

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - MedStat .... 00-162........ 151

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - MPR .... 00-159........ 150

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - Rand .... 00-160........ 149

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - RTI .... 00-156........ 150

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicaid Research and Demonstrations - UI .... 00-157........ 149

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Abt .... 00-150........ 149

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - ARC .... 00-154........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Barents .... 00-155........ 147

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Brandeis .... 00-149........ 147

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - C.N.A. .... 00-153........ 149

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - CHPR .... 00-144........ 146

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - HER .... 00-148........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Medstat .... 00-152........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - MPR .... 00-151........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations – Rand .... 00-145........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations – RTI .... 00-142........ 147

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - UI .... 00-143........ 146

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - URREA .... 00-146........ 147

Research, Analysis, Demonstration, and Survey Task Order Contract – Medicare Research and Demonstrations - Wisconsin ..... 00-147........ 148

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – Abt .... 00-133........ 145

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – ARC .... 00-134........ 145

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – Barents.. 00-135........ 145

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – Brandeis .... 00-136........ 144

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – C.N.A. .... 00-137........ 145

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – Medstat .... 00-139........ 145

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – MPR .... 00-138........ 146

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis – RTI .... 00-140........ 146

Research, Analysis, Demonstration, and Survey Task Order Contract – Policy Analysis - UI .... 00-141........ 145

Retiree Health Benefits .... 00-118.......... 46

Rhode Island RIte Care, Department of Human Services ...... 94-104.......... 90

Risk Adjustment Implementation for Medicare Demonstrations .... 00-019.......... 19

Risk Factors Unique to Early Onset Pneumonias .... 01-051........ 139

S

Second Generation Social Health Maintenance Organization Demonstration: Florida .... 99-271.......... 16

Second Generation Social Health Maintenance Organization Demonstration: Nevada .... 95-088.......... 16

Social Health Maintenance Organization Project for Long-Term Care
- Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care) .... 84-004.......... 17
- Kaiser Permanente Center for Health Research .... 84-006.......... 17
- SCAN Health Plan .... 84-007.......... 16

South Carolina Welfare Reform Family Independence Act .... 96-063.......... 55

State Licensure and Certification Standards and Respiratory Therapy Competency Examinations............. 01-109........ 110

State of Minnesota Senior Health Options (MSHO) Project 95-089 99

Strategies to Improve Prostate Cancer Screening Rates Among African-American Men in the Baltimore Metro Area 01-244 130

Studies in Home Health Case Mix 01-233 32

Study of Medicare Payments in Health Professional Shortage Areas 99-045 41

Study of the Impact of Boren Amendment Repeal on Nursing Facility Services for Medicaid Eligibles 00-094 34

Study on Medicare Coverage of Routine Thyroid Screening 01-277 111

Studying Migrant and Seasonal Farm Workers 01-149 135

Support for Research and Analytic Activities - ANASYS 00-172 144

Support for Research and Analytic Activities - IQ Solutions 00-171 144

Support for the Redesign of the Medicaid Statistical Information System 01-266 127

Survey of Medicare Beneficiaries Who Were Involuntarily Disenrolled from HMOs that Withdrew from Medicare or Reduced their Service Areas 00-111 13

Survey of Renal Dialysis Centers 02-059 20

Survey Result from the Retail Method of Payment Database - II 01-249 126

System Change for Community Living - Offering of Informed Choices – Iowa 01-174 84

T

Tabulate Data from the National Employer Health Insurance Survey 96-049 123

Tabulating Medicare Current Beneficiary Survey (MCBS) Data by Type of Service and Age Group 98-259 142

Telephone Customer Service Strategy – Customer Satisfaction 99-031 5

Tennessee “Families First” Demonstration 96-043 52

Testing Comprehensive Risk Adjustment Models for Coding Gameability 01-283 20

The Effectiveness of Insuring Uninsured Latino Children Using Community-Based Case-Managers: A Randomized Trial 01-147 134

The Impact of Alternative Low Vision Intervention on Quality 01-110 109

The Impact of Prescription Drug Coverage on Medicare Program Expenditures: A Case Study of the Evaluation of the United Mine Workers' Demonstration 02-061 48

The Partnership Plan 97-266 89

Time Series Data on Nonprescription Drugs 01-278 127

Transcultural Case Management (TCM) Integrated HIV Health Care and Support Services 99-075 132

U

Ultrasound Screening for Abdominal Aortic Aneurysms .... 01-268........ 116

Understanding the Role of Culture in the Access and Utilization of Telemedicine Health Services Among Hispanic, Native Americans, and White non-Hispanic Populations .... 01-247........ 133

United States Renal Data Registry - II .... 01-250.......... 10

Using Risk Sharing and Risk Adjustment Strategies for Dealing with the Tradeoff Between Selection and Efficiency .... 02-026........ 140

V

Validation of Physician Time Data .... 99-042.......... 41

Vermont Health Access Plan (VHAP) .... 95-021.......... 88

Virginia Independence Program .... 95-063.......... 54

Index of Awardee Organizations

Ability Resources Inc. 36
Abt Associates 2, 20, 30, 31, 32, 46, 48, 98, 103, 113, 119, 145, 149, 151, 154
Actuarial Research Corporation 21, 23, 124, 145, 148, 152
Acumen, LLC 152
Advanced Renal Options 14
AFYA 127
Agency for Healthcare Research and Quality 8, 112
Alabama, Medicaid Agency 57, 74, 79
Alabama, Medicaid Agency, Long Term Care Division 57
Alaska, Department of Administration 78, 84
Alaska, Governor's Council on Disabilities and Special Education 57
Alegent Health, Immanuel Medical Center 121
Alpha One Center for Independent Living 37
American Hospital Association 123, 133, 138
American Institute for Research 154
American Management Systems 48
American Samoa, Department of Commerce 76
Analytical Science 153
ANASYS 144, 153, 154
ARCIL, Inc. 76
Arizona Health Care Cost Containment System 87
Arizona, Department of Economic Security 53
Arkansas, Department of Human Services 70, 74, 79, 84, 89, 96
Avera McKennan Hospital 28
Baptist Hospital System, Cardiac Wellness Program 122
Barents Group 2, 5, 6, 7, 8, 12, 30, 103, 110, 145, 147
Beth Israel Deaconess Medical Center 121
Boston Medical Center Corporation 134
Boston University 19, 140
Boston University, Graduate School of Arts and Sciences, Department of Economics 140
Bowie State University, Department of Nursing, Center for Learning and Technology 131
Brandeis University, Heller Graduate School, Institute for Health Policy 10, 34, 104, 119, 144, 147
BroMenn Healthcare, Department of Cardiology 121
Bronx-Lebanon Hospital Center 40
Bucks County Health Improvement Project, Inc 85
C.N.A. Corporation 95, 109, 115, 145, 149, 150
California, Department of Health Services 56, 57, 90
Care New England Wellness Center 121
Carle Foundation Hospital 28
Center for Health Policy Research, University of Colorado 14, 26, 32, 44, 113, 115, 146, 151
Center for Independent Living of Southwest Pennsylvania 37
Center for Living and Working 37
CenVaNet 28
CHD Research Associates 3, 40, 106, 117, 118, 123, 124, 125, 126, 142, 155
City of Baltimore 43
City of Milwaukee 44
City of San Jose 45
Colorado, Department of Health Care Policy and Financing 57, 78
Columbia University 25, 26
Commonwealth of Massachusetts, Division of Medical Assistance 94
Community Coalition for Long Term Care 100
Connecticut, Department of Social Services 58, 78
Conwal, Inc 72
Cook County, Bureau of Health Services 110
CorSolutions Medical, Inc 29
Dartmouth University 112, 116
Data Computer Corporation of America 127
Debra Buckwald, MD 105
Delaware, Health and Social Services, (Dover) 74, 80
Delaware, Health and Social Services, (New Castle) 52
Delaware, Health Care Commission 58
Delmarva Foundation for Medical Care 114, 120

CMS CENTERS for MEDICARE & MEDICAID SERVICES

DisABILITY LINK ... 76
District of Columbia, Department of Health, Medical Assistance Administration ... 58, 65
DRI ... 126
Duke University, Health System ... 110
Econometrica, Inc. ... 152
Elderplan, Inc. ... 17
Eleanor Walker, Ph.D ... 104
Elena Yu ... 105
Equip for Equality ... 102
Erickson Retirement Community, Inc ... 29
Executive Office of Health and Social Services ... 54
Florida, Agency for Health Care Administration, (Ft Knox Blvd) ... 56
Florida, Agency for Health Care Administration, (Mahan Dr) ... 73, 96
Florida, Department of Elder Affairs ... 16
Florida, Department of Management Services ... 80
Fu Associates ... 4, 19, 126
Georgetown University ... 28
Georgia, Department of Community Health ... 58, 78
Good Samaritan Hospital, Health Lifestyle Program ... 120
Granite State Independent Living ... 85
Great Rivers Independent Living Services, Inc. ... 76
Guam, Department of Integrated Services for Individuals with Disabilities ... 84
Guam, Department of Public Health and Social Services ... 80
Guam, Developmental Disabilities Council ... 76
Harlem Hospital Center ... 38
Hawaii, Department of Human Services ... 80, 91
Health Economics Research ... 1, 2, 11, 14, 18, 19, 21, 22, 24, 25, 40, 41, 43, 65, 88, 94, 101, 103, 105, 107, 108, 143, 148, 150, 152, 154
Health Plan of Nevada, Inc. ... 16
Health Quality Partners ... 28
Health Services Advisory Group ... 124, 155
Hebrew Rehabilitation Center for the Aged ... 18
Highmark Blue Cross/Blue Shield ... 121
Hospice of the Valley ... 30
Howard University, College of Medicine ... 136
IBM ... 127
Idaho, Department of Health and Welfare, (Amer. Terr) ... 59
Idaho, Department of Health and Welfare, (State St) ... 80
Illinois, Department of Human Services ... 80
Illinois, Department of Public Aid, (South Grand Ave) ... 59
IMS America ... 126
Independent Living Research Utilization ... 71
Indiana, Family and Social Services Administration ... 75
InterStudy Publications ... 127
Iowa, Department of Human Services ... 59, 72, 84
Iowa, Department of Public Health ... 48
IQ Solutions ... 143, 144, 151, 156
Island Peer Review Organization ... 114
Jacobi Medical Center ... 39
JEN Associates, Inc. ... 152
Jing Xing Technologies ... 9, 33, 125, 153, 154
Johns Hopkins University ... 139, 141
Kaiser Permanente Center for Health Research ... 17
Kansas, Department of Social and Rehabilitation Services ... 59, 77
Kathpal Technologies ... 112
Kentucky, Cabinet for Health Services ... 80
Kentucky, Department for Medicaid Services ... 87
Klemm Analysis Group, Inc. ... 153
Kline & Company ... 127
KPMG Consulting ... 27
L. Sue Anderson ... 45
Laguna Research Associates ... 31
Lewin Group ... 3, 5, 13, 18, 37, 42, 45, 66, 71, 150
Lincoln Medical and Mental Health Center ... 40
Los Angeles Care Health Plan ... 86
Louisiana, Department of Health and Hospitals ... 60, 67
Maimonides Medical Center ... 39
Maine, Department of Human Services ... 60, 70, 81
Maryland ... 29, 78, 81, 88, 89, 96, 97, 98, 114, 130, 138
Maryland, Department of Health and Mental Hygiene ... 88, 98
Maryland, Department of Human Resources ... 78
Massachusetts ... 31, 54, 60, 73, 75, 81, 94, 132, 135
Massachusetts General Hospital ... 132, 135
Massachusetts, Department of Mental Retardation ... 75
Mathematica Policy Research, (DC) ... 1, 3, 4, 23, 26, 49, 53, 66, 150, 154
Mathematica Policy Research, (Princeton) ... 15, 25, 100, 102, 146, 148

Medical Care Development 28
Medical Education Council 40
MEDSTAT Group (DC) .... 5, 12, 34, 48, 108, ... 145, 148, 151
Meharry Medical College 129
Memorial Hermann Southwest Hospital 122
Mercy Medical Center - North Iowa 29
Metropolitan Hospital Center 38
Michigan Peer Review Organization 115
Michigan Public Health Institute 41
Michigan State University 135
Michigan, Department of Community Health 79, 81, 84
Mid Alabama Chapter of the Alabama Coalition of Citizens with Disabilities 75
Minnesota, Department of Human Services 60, 67, 77, 81, 84, 93, 99
Minot State University 62
Mississippi, Office of Governor, Division of Medicaid 65, 67
Missouri, Department of Social Services 60, 82, 92
Monroe County Long Term Care Program, Inc 36
Montana, Department of Public Health and Human Services 85
Morehouse, School of Medicine 128
Morgan State University 128, 130, 131
Mount Sinai Medical Center 39
National Academy of Sciences, Institute of Medicine 111
National Aeronautics and Space Administration, Goddard Space Flight Center 96
National Committee for Quality Assurance 155
National Institute of Diabetes and Digestive and Kidney Diseases 9, 10
Nebraska, Department of Health and Human Services 60, 61, 74, 82
Nebraska, Department of Social Services 55
Nevada, Department of Human Resources 61
New Hampshire, Department of Health and Human Services, (Hazen Dr) 53
New Hampshire, Department of Health and Human Services, (Pleasant St) 69, 79, 82
New Jersey, Department of Human Services 61, 82, 90, 96
New Mexico, Department of Human Services, Medical Assistance Division 62, 91
New York Hospital & Presbyterial Hospital 38
New York University Medical Center 40
New York, Department of Health, (Albany) 62, 67, 89, 96
New York, Department of Health, Bureau of Continuing Care Initiatives 101
NORC 154
North Carolina, Department of Health and Human Services 55, 67, 74, 77, 82
North Dakota 67, 86
Office of the Assistant Secretary for Planning and Evaluation 10, 96, 111
Ohio State University Research Foundation 110, 141
Ohio, Department of Job and Family Services 62, 73, 77
Oklahoma, Department of Human Services 85
Oklahoma, Health Care Authority 62, 93
Olgivy, Seniors Research Group 118
Oregon Health and Science University 102
Oregon, Department of Human Services 62, 83, 89
Organization for Economic Cooperation and Development 125
Palmetto Government Benefits Administrators 37
Park Nicollet Institute 20
Partners for a Healthier Community 68
Pennsylvania, Department of Public Welfare 63, 69, 77
Ponce School of Medicine 134
Prairie View A&M University 129
PriceWaterhouse Coopers 12
Project Hope, Center for Health Affairs 153
QMED 30
Quality Oncology, Inc 28
Quality Resources Systems 153
RAND Corporation .... 10, 12, 41, 43, 117, ... 118, 148, 149, 154
Research Triangle Institute, (DC) .... 13, 15, 24, ... 31, 75, 93, 106, 155
Research Triangle Institute, (NC) .... 6, 7, 35, 47, ... 49, 95, 101, 106, 116, 142, ... 146, 147, 150, 154
Rhode Island Quality Partners 115
Rhode Island, Department of Human Services 63, 65, 74, 85, 90
San Diego State University Foundation, College of Health and Human Services 139
SCAN Health Plan 16
Shelby County Health Care Corporation, d/b/a Regional Medical Center at Memphis 68

South Carolina, Department of Health and Human Services....55, 73, 83, 97
South Dakota, Department of Human Services.... 63
Southern University and A&M College.... 128, 129
Southern University and A&M College, School of Nursing.... 128
St. Joseph Regional Medical Center.... 122
Stanford University.... 135, 138
Stanford University, School of Medicine, Hispanic Center for Excellence.... 135
Substance Abuse and Mental Health Services Administration, CMHS, DKDSC.... 97
Swedish American Center for Complementary Medicine.... 121
Syracuse University.... 139
Tennessee State University.... 131
Tennessee, Department of Human Services.... 52
Tennessee, Department of Mental Health and Developmental Disabilities.... 83
Texas, Department of Human Services.... 52
Texas, Health and Human Services Commission....63, 65, 67, 77
The Gallup Organization, Government Division.... 153
The Jewish Home and Hospital for the Aged.... 29
Trustees of Dartmouth College, Office of Grants and Contracts.... 117
Tuskegee University.... 130
United States/Mexico Border Counties Coalition.... 47
University of Arizona, Arizona Board of Regents.... 132
University of Arizona, Cancer Center.... 133
University of California at Berkeley.... 137
University of California at San Francisco.... 134
University of Maryland, Baltimore County.... 137, 138
University of Maryland, School of Medicine.... 29
University of Massachusetts Medical School....60, 81
University of Massachusetts Medical School, Office of the Chancellor.... 60
University of Michigan, School of Public Health.... 137
University of Minnesota, (Wash Ave).... 18, 99
University of Minnesota, School of Public Health....107, 140, 141
University of Missouri - Kansas City, Office of Research Administration.... 33
University of Pittsburgh, Office of Research.... 119
University of Rochester, School of Medicine.... 136
University of Texas Health Science Center at Houston.... 132
University of Texas Health Science Center at San Antonio.... 135
University of the District of Columbia.... 131
University of Wisconsin – Madison....8, 13, 35, 46, 49, 148
University Renal Research and Education Association....20, 147
Urban Institute....11, 25, 34, 42, 86, 92, ...117, 145, 146, 149
Utah, Department of Health....63
Vermont, Agency of Human Services....83, 88
Virginia Health Quality Center....115
Virginia, Department of Health and Human Services....54
Waimanalo Health Center....68
Walter R. McDonald & Associates, Inc.....152
Washington University Physician Network....29
Washington, Aging and Adult Services Administration....74
Washington, Department of Social and Health Services....64, 67
West Virginia Medical Institute....72
West Virginia Research Corporation, West Virginia University....109
West Virginia, Division of Rehabilitation Services....64
Westat Corporation....111, 142, 154
Westchester Medical Center....38
Western Governor's Association....86
Woodhull Medical and Mental Health Center....38
Wyoming Institute for Disabilities, University of Wyoming....64
Wyoming, Department of Health....67, 77

Index of Principal Investigators

Adcock, Malcolm 44
Agodoa, Lawrence 10
Akina, Charman 68
Akpan, Samuel 44
Alecxih, Lisa Maria 45
Allen, Charles 54
Amin, Ruhul 128
Anderson, Ellen 89
Anderson, L. Sue 45
Apodaca, Richard 142
Archangelo, Elaine 52
Atkins, Nancy 79
Baghelai, Cyrus 152
Bailey, K. Michael 67
Bailey, Robert 37
Barone, Susie 122
Becker, Alison 75
Becker, Ross 91
Berk, Marc 153
Berkman, Nancy 142
Bernard, Shulamit 101
Besteman, Jacqueline 112
Betancort, Joseph 135
Bezanson, Lee 82
Bhalotra, Sarita 104
Biedess, Phyllis 87
Bishop, Christine 34
Blackstone, Charlene 151
Blake, JoAnn 129
Blessing (contact Denise Leonard), Linda 53
Blouke, Peter 51
Booske, Bridget 8
Borja, Victor 84
Bouldouc-Musumeci, Deinse 61
Bowen, Bo 65
Bowen, Claude 145
Braunstein, Allison 29
Briefer-French, Jessica 155
Briesacher, Becky 137
Brown, Heidi Robbins 67
Brown, Randall 148
Buckwald, Debra 105
Burwell, Brian 5
Byrant, Lara 140
Caffrey, Christine 139
Cahill, Kenneth 103
Calley, Karen 96
Camacho, Peter John 80
Camp, Skip 119
Capitman, John 104
Carpenter, Christopher 137
Carpi, Ken 47
Carter, Grace 43
Casey, Aggie 121
Chambless, Catherine 63
Chandler, Susan 80
Chang, Debbie 88
Cheh, Valerie 15
Chow-Menzer, Marcaret 75
Cillessen, Dan 55
Clarake-Helms, Linda 115
Cleneay, Roland 28
Coburn, Kenneth 28
Coggin, Cathy 48
Conway, Terrence 110
Cooper, Cathy 121
Corker, Bob 52
Corrigan, Janet 111
Coughlin, Terri 92
Coulam, Robert 2
Cox, Michael 30
Coyle, Carmela 123
Crisler, Kathryn 115
Crisp, Suzanne 70
Cromwell, Jerry 105
Cronenwett, Jack 112, 117
Curtis, Pat 59
Dahlman, Celia H. 117
DaVanzo, Joan 5
Davenport, Regina 84
Davis, Lucille 128
Dayhoff, Deborah 105
Deutsch, Teri 126
Ditto, William 61
Dobson, Allen 42
Dodds, Suzanne 4
Downey, Carol 78
Downie, James 62
Drennan, Diane 122
Eddy, Erin 122
Edwards, Barbara 73
Edwards, W. Sherman 154
Eggert, Gerald 36
Elison, Gar 40

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ellington, Fran ... 58
Elliott, Eileen ... 88
Ellis, Deborah ... 96
Enichen, Dan ... 146
Enichen, Don ... 148, 150
Enomoto, Kana ... 97
Ervin, Sam ... 16
Espino, David ... 135
Fabian, Sally ... 85
Farley, Donna ... 154
Faucette, David ... 154
Feldman, Arthur ... 119
Feldman, Eli ... 17
Felt-Lisk, Sue ... 146
Ferguson, Alexandra ... 146
Ferguson, Christine ... 90
Ferguson, Marilyn ... 79
Ferreira-Pinto, Joao ... 132
Fink, Brenda ... 81
Fischman, Michael ... 150
Fisher, Nancy ... 29
Flores, Glenn ... 134
Florio, Deborah ... 85
Fomby, Betty ... 129
Foreman, JoAnn ... 45
Forrester-Anderson, Ivis ... 130
Forsythe, James ... 72
Fozman, Joy Hogan ... 115
Frank, Andreas ... 111
Frechtling, Joy ... 6
Freiman, Marc ... 103
Fries, Brandt ... 9
Fu, Edward ... 19
Gage, Barbara ... 1
Galea'I, Pat ... 76
Garcia, Francisco A.R. ... 132
Garcia, Manual ... 140
Garcia, Ronald ... 135
Garfinkel, Steven ... 11
Garland, Carey ... 85
Garrett, Joseph ... 154
Gavin, Norma ... 95
Germain, John ... 125
Gianopoulos, Christine ... 60
Gilden, Dan ... 152
Glendenning, Jennifer ... 80
Gold, Heather Taffet ... 136
Goldberg, Henry ... 31
Goldstein, Elaina ... 63
Gomez, Cynthia ... 134
Goodwin, Kathryn ... 36, 37
Gottlieb, Steven ... 29
Gowdy, Linda ... 101
Grant, Carol ... 82
Green, Teri ... 67
Greene, Angela ... 35
Greene, Bernadette ... 43
Gregory, Don ... 67
Grigsby, Jim ... 26
Haber, Susan ... 21
Halford, Nancy ... 29
Halpern, Rachel ... 140
Hamilton, Edith ... 33
Hanes, Pamela ... 102
Hanley, Ray ... 89
Hargreaves, Margaret ... 129
Harmon, Virginia ... 79
Harris, Patricia ... 57
Hatzman, Majorie ... 5
Haydon, Barbara ... 121
Held, Philip ... 147
Helton, Jimmy ... 87
Hennessy, Kevin ... 10
Hillegass, Bonnie ... 16
Himmelstein, Jay ... 81
Hiramatsu, Aileen ... 91
Hockenbarger, Karl ... 77
Hoerger, Thomas ... 49
Hogan, Paul ... 66
Holland, Janice ... 64
Holt, Barbara ... 112
Holtz, Deb ... 84
Holzworth, Donald ... 153
Horn, Adelaide ... 77
Howell, Embry ... 53
Huaber, Manfred ... 125
Huddleston, Julia ... 83
Husaini, Baqar ... 131
Irvin, Carol ... 102
Ives, Colleen ... 85
Iwan, Mary Jo ... 82
Jain, Susheel ... 29
Jaynes, Cathy ... 141
Johnson, Sharon ... 59
Jongewaard, Joseph ... 48
Joyner, LaMont ... 127
Kane, Rosalie ... 107
Kapowich, Joan ... 89
Karon, Sara ... 101
Karon, Sarita ... 35

Kayala, Dianne....74
Keller, Susan....116
Kelly, Joe....90
Kendall, Linda....78
Kennedy, Mary....93
Kennedy, Ruth....60
Kessler, Daniel....75
Kickul, Grady....63
Kidder, David....145
King-Sutton, Betty....55
Kiser, Gina....67
Klemm, Bebecca....153
Knable, Steven....154
Knoble-Ivevson, Kathie....76
Knutson, David....20
Kotula, Kathryn....77
Kowalczyk, George....9
Kownick, Dana....121
Kozak, Stephen....64
Krenz, Vickie....133
Kruzikas, Denise....136
Kulas, Elizabeth....43
Kulp, Russell....73
Kuper, David....28
LaCasse, John....28
Langwell, Kathryn....147
Laninga, Dale....69
Lara, Don....100
Larsen, Max....153
LeBrun, Aurora....67
LeClair, Linda....62
Leeds, Mark....81
Levine, Elissa....96
Lipsitz, Lewis....18
Liu, Korbin....34, 42
Loh, Evan....109
Lopez, Ana Maria....133
Loux, Donny....85
Lubalin, James....93
Luppes, Steve....121
Luzky, Steven....65
Lynch, John....29
Lyons, Pamme....86
Maberry, Robert....128
MaCurdy, Thomas....152
Madison, Kristin....138
Maggioncalda, Mary....69
Manske, Fred....118
Marek, Karen Dorman....27
Marshall, Denise....27
Maryanski, Bob....56
Matthews, Michael....28
Mattke, Soeren....30
McCall, Nancy....13
McCall, Nelda....31
McCormack, Lauren....6
McDaniel, Lynda....82
McDonald, Walter....152
McIntyre, Dennis....110
McKinney, Mike....52
McKusick, David....124
McLeod, Thomas....120
McNeill, Sam....33
Meltzer, Alfred....153
Mercer, Mary....62
Meyer, Robert....77
Milne, Dann....78
Mitchell, Janet....152
Montealegre, Frederico....134
Moore, Terry....113
Moss, Bill....74
Mowry, MaryAlice....60
Murray, Margaret....90
Murray, Robert....150
Naiditch, Zena....102
Nonnenkamp, Lucy....17
Nowell, Robert....67
Nutt, Robert....33
Obisesan, Thomas....136
Odom, J. Vernon....109
Oleske, Iris....77
Overland, James....72, 84
Park, Joshua....153
Parker, Pamela....92
Parrella, David....78
Pelavin, Diane....154
Pennington, Margaret....80
Perez Rosenbaum, Rene....135
Petrillo, Marcia....115
Petty, Richard....71
Piel, Michele....80
Pinkett, Joyce....58
Pizer, Steve....20
Pope, Gregory....108
Porter, Amy....58
Powel, Lorrie....138
Powell, Mary Edith....130
Power, Gwen....55
Priest, Rodney....76
Prince, William....97

Quintas, Ileana 144
Ramage-Tuttle, Rebecca 76
Ramsini, Hope 77
Reinhard, Susan 71
Reynolds, Larry 14
Riley, K. 72
Ringlestein, Todd 79
Robinson, Frank 68
Robinson, James 49
Rocha, Ronald 76
Rogers, David 70
Rosenbach, Margo 3
Rosenstein, Stan 57
Ross, Nancy 73
Rubenstein, Laurence 117
Rubin, Robert 37
Ryan, Millie 57
Sanderson, Herb 79
Scally, Sue 83
Schaad, Dave 64
Schaefer, Thomas 114
Schafer, Penny 98
Schlenker, Robert 146
Schneider, Philip 110
Schoolfield, Kerry 96
Schraeder, Cheryl 28
Selleck, Carolyn 96
Senecal, Joan 83
Seward, Phil 67
Shapiro, Lawrence 155
Shaughnessy, Peter 113
Shaw, Julie 80
Shea, Steven 25
Shepard, Donald 119
Shore, Jennifer 49
Shropshire, Kelly 62
Shumway, Donald 53
Sloss, Elizabeth 118
Smith, Barbara 85
Smith, Bradley 27
Smith, Gail 58
Souby, James 86
Splinter, Garth 93
Spruill, Frank 33
Stanton, William B. 119
Stefl, Gail 62
Stern, Maria 149
Stogis, Sheryl Lynn 115
Stolarick, Robert 68
Stone, Doug 62
Stoner, Dena 65
Strowd, Richard 75
Sue, Sandra 126
Swanberg, Lisa 143
Taylor, Nora 63
Taylor, Sheri 82
Temkin-Greener, Helena 100
Thornton, Craig 66
Thorpe, Diana 83
Tompkins, Christopher 144
Trapnell, Gordon 145
Tucker, Susan 98
Tweeten, Sara Samantha 139
Tyrell, Charles 63
VanDyke, Amy 37
Volk-Craft, Barbara 30
Waldman, Beth 94
Walker, Eleanor 131
Walrath, Jo 138
Wamsley, Brenda 36
Webster, Connie 131
Welsh, James 28
Wherry, Mary 61
Whitburn, Gerald 54
Wilhelm, Amy 121
Will, Theodore 114
Williams, Marie 83
Wodchis, Walter 137
Wolf, Sheldon 67
Wolfe, Robert 9
Wolff, Jennifer 141
Wong, Steward 154
Wooldridge, Judith 25
Workman, Rhoda 78
Wright, Richard 149
Wrightson, C. William 21
Wroble, Marian 32
Wynn, Barbara 118
Yarrington, Diane 59
Yoo, Byung Kwang 139
Yu, Elena 105
Zimmerman, David 24
Zuckerman, Stephen 25
Zukas-Lessard, Christine 81

State Index of Research and Demonstration Projects

Alabama........................57, 74, 75, 79, 117, 118, 130
Alaska.............................. 57, 78, 84, 103, 104, 147
American Samoa 76
Arizona 53, 54, 87, 108, 132, 133
Arkansas 31, 70, 74, 79, 84, 89, 90, 96
California......................... 30, 31, 56, 57, 86, 90, 92,
.... 101, 133, 134, 137
Colorado 14, 26, 32, 44, 57, 78,
.... 113, 115, 146, 151
Connecticut.. 58, 78
Delaware 5, 52, 58, 74, 80, 93
District of Columbia..............3, 58, 65, 118, 119, 131
Florida............................ 16, 28, 31, 35, 37, 56, 70,
.........................72, 73, 80, 96, 101, 117, 118, 133
Georgia 58, 76, 78, 108, 128
Guam... 76, 80, 84
Hawaii.. 68, 80, 91
Idaho 59, 80
Illinois.....................10, 28, 31, 59, 80, 102, 103, 121
Indiana...75, 121, 122
International... 20, 42, 125
Iowa 29, 48, 49, 59, 72, 84, 112
Kansas 33, 59, 77
Kentucky..................................80, 81, 87, 92, 109
Louisiana...................................... 60, 67, 128, 130
Maine...............................60, 70, 81, 112, 117, 150
Maryland...............................29, 78, 81, 88, 89, 96,
.... 97, 98, 114, 130, 137, 138
Massachusetts 31, 54, 60, 73, 75, 81, 94, 132, 135
Michigan 9, 41, 79, 81, 84, 115, 135, 137
Minnesota......................... 18, 60, 67, 77, 81, 82, 84,
..............................92, 93, 99, 100, 107, 140, 141
Mississippi..................................... 65, 67, 103, 128
Missouri.........................27, 33, 60, 82, 92, 117, 118
Montana.. 51, 52, 85, 109
Nebraska 55, 60, 61, 74, 82, 117, 118, 120
Nevada..16, 18, 61, 85, 86
New Hampshire.......... 53, 61, 69, 79, 82, 85, 112, 117
New Jersey 11, 31, 61, 74, 82, 90, 96
New Mexico 62, 91
New York......................... 26, 29, 36, 38, 39, 40, 62,
....67, 89, 92, 96, 100, 101,
.... 103, 114, 133, 136
North Carolina.................. 55, 67, 74, 77, 82, 83, 140
North Dakota 67, 86
Ohio.................36, 62, 73, 77, 88, 110, 117, 118, 141
Oklahoma................................ 62, 85, 93, 117, 118
Ontario 89
Oregon 62, 63, 83, 89, 101, 102
Pennsylvania............31, 37, 63, 69, 77, 101, 108, 109
Puerto Rico....................................... 118, 119, 134
Rhode Island...................63, 65, 74, 85, 90, 115, 121
South Carolina................................... 55, 73, 83, 97
South Dakota 63
Tennessee.................................... 52, 83, 129, 131
Texas 29, 31, 35, 37, 52, 63, 65,
.... 67, 76, 77, 103, 112, 132, 135
Utah.. 40, 63
Vermont.................................. 83, 88, 92, 112, 117
Virgin Islands... 118
Virginia 28, 54, 64, 77, 83, 109, 115, 131
Washington................................29, 64, 67, 74, 108
West Virginia 36, 64, 72, 79, 109
Wisconsin...........................8, 13, 31, 35, 46, 49, 76,
....95, 100, 103, 108, 148
Wyoming............................64, 67, 77, 86, 117, 118

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..............................106, 125

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..............................106, 125

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Information....... 96, 103, 105,
..............................106, 125

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Information............9, 10, 13,
.... 26, 109

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State Operations.... 72, 74, 76,
.... 77, 78, 81,
............................82, 83, 84

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Choices 155

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Information.............3, 10, 49,
..............................103, 117

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Operations 56, 76, 78,
.... 96, 113

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.... 96, 113

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.... 96, 113

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........................119, 144, 147

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Choices 35, 116

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............................62, 63, 64

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.................................78, 96

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Facts About The Centers For Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is responsible for the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and quality standards in health care facilities through its survey and certification activity.

Through Medicare, Medicaid and SCHIP, about one in four Americans receive health care coverage. Nearly 40 million people are covered by Medicare, about 33 million are eligible for Medicaid, and SCHIP helps States expand health coverage to as many as 5 million uninsured children. These programs spend about one in three of the Nation's health care dollars, about $429 billion in 2000 (of which the Federal share was $344 billion). CMS spends nearly one in five of the Federal Government's dollars.

The Medicare Program

Medicare, the nation's largest health insurance program, covers nearly 40 million Americans. Enacted in 1965, the program provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain individuals under 65 with disabilities.

Original Medicare

The fee-for-service Medicare program has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part A helps pay for inpatient hospital services, skilled nursing facility services, certain home health services, and hospice care. Medicare Part B helps pay for doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies. Generally, outpatient prescription drugs are not covered.

Since its inception, Medicare has contracted with insurance companies to administer the program. A Fiscal Intermediary is a private company that Medicare contracts with to pay hospitals, skilled nursing facilities, and home health agencies for their Part A and some Part B bills. A Carrier is a private company that Medicare contracts with to pay physicians and other suppliers for their Part B bills.

Original Medicare is fee for service, available everywhere in the United States. Beneficiaries are free to go to any doctor, specialist, or hospital that accepts Medicare and most providers participate in Medicare. Beneficiaries and Medicare share the bill. About 85 percent of beneficiaries are in Medicare fee for service.

Medicare+Choice

While Medicare has contracted with health maintenance organizations (HMO) on a risk basis since 1987, the Balanced Budget Act of 1997 (BBA) added Part C to Medicare, called Medicare+Choice. The Act expanded the types of private health plans (such as private fee-for-service, medical savings accounts, preferred provider organizations, and provider-sponsored organizations) with which CMS can contract. Medicare+Choice permits Medicare beneficiaries to select health plans, available in many areas of the country, where beneficiaries go to doctors, specialists, or hospitals that participate in the plan. In a private fee-for-service plan, enrollees generally can see any Medicare-participating provider. Some managed care plans cover extra benefits, like outpatient prescription drugs and hearing aids. In March 2002, there were 149 Medicare+Choice managed care plans with 5 million enrollees.

The BBA reduced the wide geographic variation in payment levels to health plans and adjusted payments for the health status of enrollees. The limits on payment increases, combined with other market forces, have made it difficult for some plans to continue to offer extra benefits - with the result that many plans have scaled back their Medicare offerings or left the Medicare market entirely.

The Medicaid Program

Medicaid beneficiaries include low-income families with children, aged, blind or disabled people on Supplemental Security Income, certain low-income pregnant women and children, and certain people who have very high medical bills. Generally, individuals who are poor, but who have no dependent children and are not disabled, no matter how low their income, may not qualify for Medicaid coverage. Exceptions to this rule are some expansion populations in certain States with "section 1115 waivers."

Medicaid was originally enacted in 1965 as a jointly funded program where the Federal Government matches State spending to provide medical and health-related services. Although there are broad Federal requirements for Medicaid concerning eligibility, benefits, and provider payments, States have a wide degree of flexibility to design their programs. The portion of the Medicaid program that is paid by the Federal Government is known as the Federal Medical Assistance Percentage. It is determined annually for each State by a formula that compares the State's average per capita income level with the national average (the Federal Government matches at least half of State spending).

States have the authority to establish eligibility standards, set the rate of payment for services, and determine the type, amount, duration, and scope of services. Because States have this flexibility, there are considerable variations from State to State.

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their higher income. Many elderly in nursing homes eventually become eligible for Medicaid through this program.

The most significant trend in service delivery is the rapid growth in managed care enrollment within Medicaid. By the end of the 1990s, States had moved more than half of their mothers and children into managed care programs (defined broadly) in an effort to contain costs and link participants with a primary care provider.

States often seek waivers of certain Medicaid requirements in order to implement Medicaid managed care. Under "section 1915(b) waiver authority," States can require individuals be covered by Medicaid to enroll in managed care, use the resulting savings to provide additional services and create innovative delivery systems for specialty care. In addition to the changes that are possible under section 1915(b), States with section 1115 waivers can use managed care savings to extend Medicaid eligibility to new populations, or demonstrate new approaches to coverage or payment.

Medicaid - Medicare Relationship

Medicare beneficiaries who have low income and limited resources may receive help paying for their Medicare premiums and out-of-pocket medical expenses through Medicaid. There are various benefits available to "dual eligibles," about six million Medicare beneficiaries are eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. For services that are covered by both programs, Medicare pays first, and Medicaid pays for the beneficiary's cost sharing (up to the State's payment limit). Medicaid also covers additional services. Limited Medicaid benefits are also available to pay for out-of-pocket

Medicare cost-sharing expenses and Medicare Part B premium for certain other Medicare beneficiaries with low income and/or disabilities.

BALANCED BUDGET ACT OF 1997

The BBA made the most significant changes to the Medicare and Medicaid programs since 1965. It extended the life of the Medicare Part A Trust Fund by reducing Medicare spending; increasing health care options available to America's seniors; improving Medicare preventive benefits; supporting efforts to fight waste, fraud, and abuse; providing new demonstrations to help Medicare work well in the future; creating a new program, SCHIP, intended to cover half of the Nation's uninsured children; and providing States with new flexibility to administer Medicaid.

The Balanced Budget Refinement Act was enacted in 1999 and modified some of the payment reductions of BBA.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

States may initiate and/or expand health insurance to uninsured, low-income children by designing a new children's health insurance program, expanding current Medicaid programs; or a combination of both strategies. The program is the most significant improvement in access to health care for children since the creation of Medicaid, currently covering about 2 million out of the estimated 11 million uninsured children in the U.S.

SCHIP is a capped entitlement for States, funded by a State-Federal partnership. Congress appropriated $24 billion over 5 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance. All States are participating in the program. CMS has worked in concert with many partners, in the public and private sectors, to encourage eligible families to sign their children up for coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Department of Health and Human Services, the Department of Labor, and the Department of Treasury each have roles in implementing the insurance reform provisions of the Health Insurance Portability and Accountability Act (HIPAA). CMS works with States to comply with the small group and individual market provisions of HIPAA. The law is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. For the first time, the Act applies the same rules governing portability of health insurance coverage across the large group, small group, and individual insurance markets. It limits the application of pre-existing condition clauses and imposes requirements concerning mental health parity.

QUALITY IMPROVEMENT

In addition to providing health insurance through our programs, CMS performs a number of quality-focused activities that benefit all Americans. These activities include minimum quality standards through the survey and certification of health care facilities. State surveyors visit a certain number of facilities each year to determine compliance with CMS quality standards and investigate complaints from the public. We also regulate *all* laboratory testing (whether provided to beneficiaries of our programs or to others) under the Clinical Laboratory Improvement Amendments.

Under the Quality Improvement (formerly Peer Review) Organization program, CMS contracts with 53 independent physician organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. CMS is further working to improve the quality of health care by measuring and improving outcomes of care, educating health care providers about quality improvement opportunities, and educating beneficiaries to make good health care choices.

Program Integrity

The Medicare Integrity Program, established by HIPAA, gives CMS authority to try new contracting approaches for program safeguard activities. CMS selects 12 special contractors to do medical reviews and other tasks to stop and prevent fraud, waste and abuse.

Healthcare Integrated General Ledger Accounting System

The Healthcare Integrated General Ledger Accounting System (HIGLAS) is the main focus of a long-term project to modernize Medicare's accounting systems in order to improve the program's fiscal accountability to beneficiaries and taxpayers. HIGLAS will replace the many outdated accounting systems currently used by Medicare contractors, which process and pay nearly 3 million Medicare claims a day, with a single, unified system that will better ensure the program pays correctly for the care Medicare beneficiaries need.

CMS—Facts about the Agency

CMS's national headquarters is located in Baltimore, Maryland. The 10 regional offices work with the contractors who administer the Medicare program and work with the States who administer the Medicaid, SCHIP, HIPAA, and survey and certification of health care providers. We work closely with the Social Security Administration (SSA) to provide information about Medicare to beneficiaries applying for, or currently receiving, retirement or disability benefits at local SSA district offices.

Availability of Project Reports and Results

As extramural research projects sponsored by the Centers for Medicare & Medicaid Services (CMS) are completed, the final reports are placed with the National Technical Information Service (NTIS) for public access. For these reports, the NTIS accession number is included in the project write-up for ordering purposes. Further information may be obtained from: National Technical Information Service, Document Sales, 5285 Port Royal Road, Springfield, VA 22161, (703) 605-6000. Information about NTIS reports is available on the Internet at *http://www.ntis.gov.*

A few reports are published by CMS. These reports are available for purchase from the U.S. Government Printing Office (GPO). Reports must be ordered directly from GPO. Again, the stock number of a published report is included in the project write-up. These reports may be ordered by contacting GPO at (202) 512-1800 ext.1. Information about GPO published reports is also available on the Internet at *http://bookstore.gpo.gov.*

A list of research reports produced by CMS may be viewed on our web site and some reports are also available for viewing and downloading on this same site: *http://www.cms.hhs.gov.*

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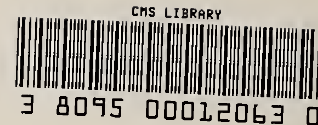
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