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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Cheryl Schraeder to Barbara Woolley re: phone number (partial) (1 page)	07/07/2000	P6/b(6)
002. memo	Marjorie Vanderbilt to Barbara Woolley re: Meeting on Friday (partial) (1 page)	04/12/2000	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:
CNO [Community Nursing Organization]

2012-0463-S
rc737

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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7/7/00

TO: Barbara Woolley
Special Assistant to the President
And Associate Director for Public Liason
FAX: 202-456-6218

FROM: Cheryl Schraeder, PhD, RN
Home: P6/(b)(6) [061]
Work: 217-586-4164
FAX: 217-586-2174
Email: CherSchra@aol.com

SUBJECT: White House CNO Questions

Pages: 5

Per your request are the questions we hope to have answered in our call on 7/11/2000 and a copy of the proposed CNO legislation for your review. We appreciate your time and continued support of the CNO Demonstration. If you have any questions please contact me. Thank you.

QUESTIONS FOR CONFERENCE CALL ON MEDICARE CNO ISSUES

1. Legislative action is unlikely until some time in October. Deep cuts in payments to CNOs are currently scheduled to begin on October 1 (following 3 months of less onerous reductions). Unless there is a real prospect that the October 1 cuts can be averted, most of the CNO sites will be forced to notify HCFA of their intention to exit the program in order to comply with HCFA's 60-day notice requirement and minimize financial losses from these cuts. If the CNOs can demonstrate substantial Congressional support for legislation relief, will the Administration take administrative action to temporarily forestall the October 1 cuts until Congress can act?

2. If the answer to question 1 is "yes", what evidence of Congressional support would the Administration need to take administrative action?

3. What changes (if any) would the Administration require to the draft legislative proposal developed by the CNOs?

4. The current uncertainty about the future of the CNOs raises the difficult question of how the four sites should communicate with their Medicare enrollees on the issue, particularly since beneficiaries have already been told that last year's legislation continued the program through 2001. On the one hand, the CNOs want to avoid unnecessarily upsetting their members, but on the other they want to fulfill their obligation to prepare them for possible future disruptions to their care. What course of action does the Administration advise the CNOs to take?

SEC. __. REVISED TERMS AND CONDITIONS FOR EXTENSION OF MEDICARE CNO DEMONSTRATIONS.

(a) IN GENERAL.--Section 532 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (42 U.S.C. 1395mm note), as incorporated by reference into Public Law 106-113, is amended--

(1) in subsection (a), by striking the second sentence; and

(2) by striking subsection (b) and inserting in lieu thereof the following:

"(b) TERMS AND CONDITIONS.--

"(1) JANUARY THROUGH SEPTEMBER 2000.--For the 9-month period beginning with January 2000, the demonstration project shall be conducted under the same terms and conditions as applied to such demonstration during 1999.

"(2) OCTOBER 2000 THROUGH DECEMBER 2001.--For the 15-month period beginning with October 2000, the demonstration shall be conducted under the same terms and conditions as applied to such demonstration during 1999, except that the following modifications shall apply:

"(A) BASIC CAPITATION RATE.--The basic capitation rate paid for services covered under the demonstration (other than case management services) per enrollee per month shall be basic capitation rate paid for such services for 1999, reduced by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York.

"(B) TARGETED CASE MANAGEMENT FEE.--A case management fee shall be paid only for enrollees who are classified as "moderate" or "at risk" pursuant to a standardized written health risk assessment that is conducted with respect to each enrollee on an annualized basis.

"(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.--Each site of the demonstration shall implement--

"(i) protocols for periodic telephonic contact with enrollees based on--

"(I) the results of such standardized written health assessment; and

"(II) the application of appropriate care planning approaches;

"(ii) disease management programs for targeted diseases (such as congestive heart failure, arthritis, diabetes, and hypertension) that are highly prevalent in the enrolled populations;

"(iii) systems and protocols to track enrollees through hospitalizations, including pre-admission planning, concurrent management during inpatient hospital stays, and post-discharge assessment, planning, and follow-up; and

"(iv) standardized patient educational materials for specified diseases and health conditions.

"(D) QUALITY IMPROVEMENT.--Each site of the demonstration shall implement, on an annualized basis--

"(i) standardized enrollee satisfaction surveys;

"(ii) reporting on specified quality indicators for the enrolled population.

"(E) ANNUALIZED BASIS.--For purposes of this paragraph, the term 'on an annualized basis' means, with respect to such 15-month period, not more than once during such period.

"(c) EVALUATION.--

"(1) PRELIMINARY REPORT.--Not later than July 1, 2001, the Secretary of Health and Human Services (hereafter in this section referred to as the 'Secretary') shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate, a preliminary report that--

"(A) evaluates the demonstration project for the period beginning July 1, 1997 and ending December 31, 1999, on a site-specific basis with respect to the impact on per beneficiary spending, specific health utilization measures, and enrollee satisfaction; and

"(B) includes a similar evaluation of the demonstration project for the portion of the extension period that occurs after September 30, 2000.

"(2) FINAL REPORT.--The Secretary shall submit a final report on the demonstration not later than July 1, 2002. Such report shall include the same elements as the preliminary report required by paragraph (1).

"(3) METHODOLOGY FOR SPENDING COMPARISONS.--Any evaluation of the impact of the demonstration on per beneficiary spending included in such reports shall be based on a comparison of--

"(A) data for all individuals who--

"(i) were enrolled in the demonstration as of the first day of the period under evaluation; and

"(ii) were enrolled for a minimum of 6 [REVIEW: ***consecutive***] months thereafter; with

"(B) data for a matched sample of individuals who are enrolled under part B of title XVIII of the Social Security Act and are not enrolled in the demonstration, or in a Medicare+Choice plan under part C of such Act, a plan offered by an eligible organization under section 1876 of such Act, or a health care prepayment plan under section 1833(a)(1)(A) of such Act.".

(b) EFFECTIVE DATE.--The amendments made by subsection (a) shall be effective as if included in the enactment of section 532 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (42 U.S.C. 1395mm note), as incorporated by reference into Public Law 106-113.

AMERICAN NURSES ASSOCIATION

TO: Barbara Woolley

FROM: Marjorie Vanderbilt Marjorie

DATE: June 16, 2000

RE: Community Nursing Organizations

Pursuant to our recent conversations, attached is a one-page outline of changes to the Community Nursing Organization (CNO) Demonstration Project which the CNO four sites believe would reduce expenditures.

I hope this is helpful to you. As always, I appreciate your assistance. As you know, the future of the CNO demonstration project is of tremendous importance to ANA and to nursing.

Many thanks for your help.

Attachment

456-6218

CNO Model for Continuation

The Community Nursing Organization (CNO) is a nurse-managed health care delivery system that has been in operation as a demonstration in Arizona, Illinois, Minnesota, and New York for over 5 years. The CNOs are capitated for a subset of outpatient care including Home Health, medical equipment and supplies, and outpatient physical, occupational, speech and psychological therapies. Registered nurses assist members by developing a plan of care, arranging needed services, monitoring members' health problems, educating members and their families, and collaborating with other healthcare providers. Effective October 1, 2000 the CNOs will adopt a more uniform approach that focuses on the following design and model enhancements in addition to a reduction in capitation which should ensure budget neutrality and high quality care for enrolled Medicare members.

Health Risk Assessment

- Implement a standardized process for health risk assessment and reporting at enrollment and annually which would stratify membership into well, moderate, and at risk.

Enrollment

- Maintain currently enrolled population.
- Eliminate the site cap on enrollment to maximize the opportunity for efficient processes and to optimize the impact on healthcare services.
- Institute targeted enrollment criteria which would include enrolling only those who screen as "moderate" and "at risk" at time of initial application.

Clinical

- Implement protocols for telephonic, office, home-based contact with enrollees based on a standardized written assessment and care planning approaches.
- Implement disease management programs for targeted diseases highly prevalent in the enrolled population, such as Congestive Heart Failure, arthritis, diabetes and hypertension.
- Implement proactive systems and protocols to track patients through hospitalizations to include pre-admission planning, concurrent management and post discharge assessment, planning and follow up.
- Implement standardized patient education materials for specified diseases/ health conditions.

Service Package

- Receive a monthly Case Management fee only for "moderate" and "at risk" members.
- Implement beneficiary "lock-in" as with Medicare+Choice plans.

Finance

- Implement on October 1, 2000 a reduction in the base capitation rate for Arizona 10%, New York 15%, Illinois 10% , and Minnesota 10%.

- Implement a work group with HCFA, CNO sites, and actuarial consultants who could assist in a more thorough review and revision of the CNO financial model by the end of CY 2001.

Quality Improvement

- Implement annual standardized patient satisfaction surveys.
- Implement annual reporting on specified quality indicators for the enrolled population.

Evaluation

- Conduct a retrospective evaluation of the "current" CNO that would cover the time period of July 1, 1997 – July 1, 2000. The evaluation sample would consist of all CNO members who were enrolled as of 7/1/97 and remained enrolled a minimum of 6 months as compared to a Medicare fee-for-service matched sample. Statistical adjustments would be made for all outcomes (including age, gender, race, risk status of the population, disability, and inflation). The evaluation would determine the CNO's impact on program spending, specific health utilization measures, and enrollee satisfaction. A preliminary report would be due to Congress July 1, 2001.
- Conduct an evaluation of the "new CNO" which would cover the time period October 1, 2000 – December 31, 2001. The evaluation sample would consist of all CNO members who were enrolled as of 10/1/00 and remained enrolled a minimum of 6 months as compared to a Medicare fee-for-service matched sample. Evaluation components will remain as identified in the retrospective evaluation. A preliminary report would be due to Congress on July 1, 2001 and a final report July 1, 2002.

CNO Rate Tables

Budget Neutral Rate Methodology

Abt Associates provided Medicare expenditures on a per member per month basis (PMPM) for members of the treatment and control groups for each CNO site (for 36 months after enrollment). Abt produced PMPM expenditures for: only those services provided by the CNO sites; Medicare services provided outside the CNO service delivery system for enrolled beneficiaries; and total Medicare services (CNO and non-CNO services).

The rate table uses the corrected results of the comparisons of CNO participants' use of services versus a control group from the evaluation study conducted by Abt Associates, Inc. We propose continuing the current payment rates through June 2000 (previously, we told the sites that the current rate would apply through May). We then apply a moderate reduction to the payment rates equaling 15 percent of the full reduction for the period July through September 2000. Beginning October 2000, we further reduce the payment rates on a graduated quarterly basis in order to apply the full reduction and to recapture any overpayments resulting from delaying the application of the full reduction.

This method uses the comparison of the utilization of all Medicare services including hospitals and outpatient services. This comparison captures reductions in non-demonstration services that result from the case management provided by the plans.

The actual payments to the plans will be higher than shown in the table because a portion of the payment is adjusted for health status.

Method discussed at April 11 meeting

Using Abt Associates information from the evaluation study, we calculated the difference between the cost of the CNO services received between the treatment and comparison groups, reduced the respective CNO rates by the percentage differences, and trended the new base rates (as well as the add-on case-management capitation) forward using OACT trend factors. Since the fully reduced rates represented reductions of almost 50 percent in 3 of the 4 sites, we wanted to construct a mechanism that would grant the sites time to adjust to the lower rates. As such, the sites were to be paid their 1999 rates through May 2000 and then we intended to begin a series of gradual and equal reductions every 2 months until the fully reduced rate is reached in December 2000. The rates were to be further reduced on a bi-monthly basis throughout 2001 in order to recapture the overpayments that occurred during 2000 due to the delay in implementing a reduction plan until June.

It is unfortunate that the material contained an error. We have been working closely with our contractor since this matter was called to our attention. The contractor identified a clerical mistake. Specifically, data on CNO covered services were transcribed incorrectly from spreadsheets.

CNO Demonstration
Rate Table

Monthly PMM Period	AZ	IL	MN	NY
Jan - June 2000	$ 71.41	$ 72.46	$ 68.76	$ 77.25
July - Sept 2000	$ 68.58	$ 67.95	$ 63.49	$ 71.58
Oct - Dec 2000	$ 49.13	$ 36.99	$ 26.80	$ 32.55
Jan - Mar 2001	$ 41.52	$ 28.01	$ 7.55	$ 15.88
Apr - June 2001	$ 37.96	$ 22.35	$ 7.55	$ 10.00
Jul - Sept 2001	$ 34.40	$ 16.69	$ 7.55	$ 10.00
Oct - Dec 2001	$ 30.84	$ 11.03	$ 7.55	$ 10.00
Budget Neutrality Factor	26.20%	41.10%	51.30%	48.60%

revised 4/13/00

Trimmed expenditures, as described in Section 8.2, are also shown in the table. Although trimmed expenditures for CNO services are 8-15 percent lower than total expenditures for these services, they are nevertheless greater than expenditures for the control group in every instance.

Table 8.1: Medicare Expenditure per Person per Month, 36 Months after Random Assignment

		Carle-IL		Carondelet-AZ		LAH-MN		VNS-NY	
Total Medicare expenditure per month									
All randomized beneficiaries	T	$365	[$355]	$474	[$462]	$429	[$423]	$806	[$786]
	C	$315		$437		$363		$712	
Randomized controls and currently-enrolled treatments	T	$358	[$345]	$474	[$459]	$411	[$403]	$805	[$781]
	C	$315		$437		$363		$712	
Services not covered by CNO									
All randomized beneficiaries	T	$285		$379		$345		$654	
	C	$280		$385		$332		$619	
Randomized controls and currently-enrolled treatments	T	$272		$375		$325		$639	
	C	$280		$385		$332		$619	
CNO-covered Services									
All randomized beneficiaries	T	$80	[$70]	$95	[$83]	$84	[$78]	$152	[$132]
	C	$35		$52		$31		$93	
Randomized controls and currently-enrolled treatments	T	$86	[$73]	$99	[$84]	$86	[78]	$166	[$142]
	C	$35		$52		$31		$93	

Note: Trimmed expenditures for treatment group appear in brackets. All figures are in 1997 dollars. These are population averages; all differences are statistically significant.

Figure 8.1 shows the time path of cumulative Medicare expenditure per-person per-month for individuals assigned to the treatment and control groups for each site. At each site, the discrepancy

ERROR : 4/11 CO BRIEFING

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All randomized beneficiaries	T	$365	[$355]	$474	[$462]	$429	[$423]	$806	[$787]
	C	$315		$437		$363		$712	
Randomized controls and currently-enrolled treatments	T	$357	[$345]	$474	[$459]	$411	[$405]	$805	[$782]
	C	$315		$437		$363		$712	

Services not covered by CNO

		Carle-IL	*Carondelet-AZ*	*LAH-MN*	*VNS-NY*
All randomized beneficiaries	T	$285	$379	$345	$654
	C	$280	$385	$332	$619
Randomized controls and currently-enrolled treatments	T	$272	$375	$325	$639
	C	$280	$385	$332	$619

CNO-covered Services

		Carle-IL		*Carondelet-AZ*		*LAH-MN*		*VNS-NY*	
All randomized beneficiaries	T	$80	[$70]	$95	[$83]	$84	[$78]	$152	[$132]
	C	$35		$52		$31		$93	
Randomized controls and currently-enrolled treatments	T	$78	[$59]	$106	[$88]	$67	[60]	$137	[$117]
	C	$35		$52		$31		$93	

Note: Trimmed expenditures for treatment group appear in brackets.
All figures are in 1997 dollars.

Figure 8.1 shows the time path of cumulative Medicare expenditure per-person per-month for individuals assigned to the treatment and control groups for each site. At each site, the discrepancy between the treatment and control groups is quite small in the initial months following randomization.

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MEMORANDUM

TO: Barbara Woolley
White House Office of Public Liaison

FROM: Marjorie Vanderbilt
Director, Government Affairs
American Nurses Association

DATE: April 12, 2000

RE: Meeting on Friday, April 14, 2000

In preparation for the meeting with officials from OMB and HCFA at 2:00 PM on Friday, April 14 to discuss current issues involving the four community nursing organizations, set forth below is the information you requested on the participants in that meeting:

1) Marjorie W. Vanderbilt
P6/(b)(6) L0021

2) Sheila Abood
P6/(b)(6)

3) Tori Gorman
P6/(b)(6)

4) Gerri S. Lamb
P6/(b)(6)

5) Joyce Hospador
P6/(b)(6)

6) Cheryl Schraeder
P6/(b)(6)

If you have any questions, or if I can provide any additional information, please give me a call.

As always, I appreciate your assistance. I looking forward to hearing from you as to the room where the meeting will occur as well as the participants from HCFA as well as OMB.

Thanks very much.

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BEVERLY L. MALONE, PHD, RN, FAAN
PRESIDENT

DAVID W. HENNAGE, PHD, MBA
EXECUTIVE DIRECTOR

TO: Christopher C. Jennings
Deputy Assistant Secretary to the President for Health Policy

Barbara Woolley
Special Assistant to the President and Associate Director
White House Office of Public Liaison

FROM: Marjorie W. Vanderbilt - 651-7085
Director, Government Affairs
American Nurses Association

SUBJECT: Community Nursing Organizations

DATE: September 29, 1999

Pursuant to our meeting of September 9, I wanted to bring you up to date on the Congressional efforts to reauthorize the Community Nursing Organization (CNO) demonstration project.

In 1987, Congress authorized four CNO demonstrations to test the efficacy of capitated nursing delivery organizations at providing quality services outside the nursing home setting. CNOs serve Medicare beneficiaries in home and community-based settings under contracts that provide a fixed, monthly capitation payment for each beneficiary who elects to enroll. Additional information on the CNOs is attached.

At the end of this year, the three-year authority expires for these effective projects, which serve approximately 7,000 Medicare beneficiaries in Arizona, Illinois, Minnesota and New York,. To conduct a thorough study of CNOs with valid outcomes to assess, it is necessary to extend the work of the four projects. Results from a comprehensive study will allow Congress and HCFA to assess the viability of offering Medicare CNO services permanently. More importantly, **extending the projects allows beneficiaries to remain in their homes while containing Medicare costs**.

To continue the work of the CNOs, bipartisan legislation (H.R.1999/S.1550) has been introduced in the House and Senate to extend the demonstration authority for the four CNOs for three years. In the past, the Congressional Budget Office has estimated that the budgetary impact of this proposal would be negligible. In addition, we are currently working to have language included in the Committee reports accompanying the Labor-HHS Appropriations bill for Fiscal Year (FY) 2000.

If there is not definitive action by October 1, 1999, HCFA has indicated that the CNOs will have to begin their phase-down process. In other words, if Congressional action has not occurred by October 1, the sites will no longer be permitted to accept new enrollments and must begin the necessary phase-down procedures. A copy of this directive is enclosed. In addition, I have enclosed copies of letters to HCFA from Rep. Jim Ramstad (R-MN) and Sen. Paul Wellstone (D-MN) in response to the HCFA directive.

The extension of the CNO demonstration project is one of ANA's top priorities.

It is imperative that the CNO demonstration project be reauthorized and that the CNOs receive a clear indication from HCFA by October 1, 1999 that the project will be reauthorized. The White House was very helpful in this regard in 1996. ANA would appreciate any assistance you can provide at this time.

Enclosures

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BEVERLY L. MALONE, PHD, RN, FAAN
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EXECUTIVE DIRECTOR

Community Nursing Organization Demonstration

Background

In 1987, Congress passed Community Nursing Organization (CNO) legislation directing the Health Care Financing Administration to design and test a new model of community-based care for Medicare beneficiaries. The current CNO demonstration program, which was extended in the Balanced Budget Act of 1997, provides services to more than 10,000 Medicare beneficiaries. The four participating CNO sites vary in structure and setting.

1. Carle Clinic, Urbana, IL, is a large medical group practice serving a primarily rural population.
2. Carondolet Health Services, Inc., Tucson, AZ, is a hospital-based organization.
3. Visiting Nurse Service of New York, NY, NY, is a non-profit certified home health agency.
4. Living at Home/Block Nurse Program, Minneapolis, MN, is a joint venture between a community-based non-profit nursing program and an accredited home health agency.

Over the past year, the CNOs have worked together to analyze their experience and refine the CNO model for the future. The intent of this document is to share our findings and insights with members of Congress and other key stakeholders in this Medicare program.

Analysis of CNO Data

The analysis reported in this paper, sponsored by the ANA, utilized data collected by Abt Associates, the evaluation contractors for the CNO demonstration. The HCFA evaluation, conducted by Abt Associates, used an experimental design in which program applicants were randomly assigned to treatment and control groups. Costs and use of Medicare-covered services were compared for CNO and control group members. The secondary analysis, conducted by the CNO's and described in this paper, focused on high-cost and high volume services, including hospitalization, emergency room utilization, skilled nursing facility stays, and outpatient/physician visits with one goal of identifying predictors of high-cost utilization.

Results: Medicare Service Use and Costs for CNO Members

Positive results have been obtained across sites despite varying markets reflecting high to low penetration of managed care and diverse settings operating in rural to urban environments. A nurse partner who works with the member to resolve problems and coordinate appropriate services and care across settings has been the primary intervention. Between 1994 and 1996, one

or more of the CNO sites showed reduced costs and/or reduced use of the higher cost services impacted by the CNO (e.g. hospitalizations, emergency room use, outpatient/physician visits.)

Arizona showed their treatment group, compared to their control group, had:
1. Fewer hospital admissions in 1994, 1995 and 1996
2. Shorter hospital length of stay in 1994, 1995 and 1996
3. Fewer emergency room events and less emergency room expenditure in 1996
4. Less outpatient expenditure in 1994, 1995 and 1996
5. Less hospital "short stay" expenditure in 1994, 1995 and 1996
6. Less skilled nursing facility expenditure in 1994, 1995 and 1996
7. Equivalent non CNO covered services* expenditure in 1996

Illinois showed their treatment group, compared to their control group, had:
1. Fewer hospital admissions in 1994, 1995 and 1996
2. Shorter hospital length of stay in 1995 and 1996
3. Less hospital "short" and rehabilitation/ psychiatric "long" stays expenditure in 1996
4. Less skilled nursing facility expenditure in 1994, 1995 and 1996
5. Equivalent "non CNO covered services" expenditures in 1995 and 1996

Minnesota showed their treatment group, compared to their control group, had:
1. Fewer hospital admissions in 1996
2. Shorter hospital length of stay in 1996
3. Less outpatient expenditure in 1996
4. Less emergency room expenditure in 1996
5. Less short and long stays expenditure in 1996
6. Less "non CNO covered services" expenditure in 1996

New York showed their treatment group, compared to their control group, had:
1. Fewer hospital admissions in 1996
2. Shorter hospital length of stay in 1996
3. Less outpatient and ER expenditure in 1996
4. Less short and long stay expenditure in 1996
5. Less skilled nursing facility expenditure in 1996
6. Less "non CNO covered services" expenditure in 1996

Targeting Members at Risk

Through the analysis, predictors of high Medicare costs were identified. These will be utilized by the CNO sites to allow for improved and efficient screening and allocation of resources for CNO enrollees during a continuation of the program. Predictors of high Medicare costs were identified using regression analysis. The HCFA evaluation of the CNO demonstration included extensive data about member characteristics, their health status and chronic illnesses, and their pattern of using health care services. Various predictive models were tested to find the set of factors that would most accurately identify "true" high risk individuals.

*non CNO covered services include hospital, emergency room, physician services

Members who are more likely to use high-cost Medicare services can be prospectively identified by a small set of characteristics. Perceived health status, the number of hospitalizations and emergency room visits within the previous six months, and the presence of specific chronic health care conditions are predictors of increased utilization of high-cost Medicare services.

The analysis demonstrated that a number of predictive models are successful in identifying true high-risk individuals. Each high-risk member, by definition, has a greater probability of spending significantly more Medicare dollars. The ability to accurately target these members and link them with a nurse partner to coordinate their care suggests the potential for considerable cost savings.

Goals for the CNO Extension

The goal for the extension of the CNOs is a refined model for home and community-based care utilizing nurses as care managers.

Objectives for the extension:

1. Continue the existing four demonstration sites using the current risk adjustment for three years
2. Determine, refine and transfer "best practices" from sites that have reduced cost and use of high-cost Medicare services.
3. Utilize predictors of high service use and costs to target selective allocation of nurse case management services and application of other care coordination best practices.
4. Assign highest priority to members predicted to be among those in the highest 25% of expenditures.
5. Test whether the targeting of CNO resources to high-risk members will reduce costs associated with expensive service use.
6. Refine procedures for coordinating CNO services with primary care providers.
7. Develop and refine processes for managing chronic illness.
8. Refine and test a new payment model.

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

JUL 19 1999

Dear CNO Site Director:

Thank you for submitting Community Nursing Organization (CNO) program phase down plans to us. This letter is to inform you of some activities, time lines, and dates which will be necessary to adhere to as we proceed through the phase down process of the CNO Demonstration. These dates and timelines will be consistent across sites.

Marketing

All marketing activities should be curtailed by September 15, 1999.

Beneficiary and CNO Contract Provider Notifications

The Medicare beneficiaries and providers under contract with the CNO should be given written notification no later than October 1, 1999, that the CNO demonstration ends on December 31, 1999. This is necessary to provide adequate time to prepare and assist beneficiaries in transitioning to other providers. Also, all CNO contract providers should be reminded to submit their bills to the CNO no later than February 15, 2000.

Enrollments

The last date for any new (first time) enrollments will be October 1, 1999. Reenrollments will be accepted up to and including December 1 as long as they are informed that the demonstration ends December 31, 1999.

Reassessments

Reassessments can be conducted up to December 31, 1999, to avoid HCFA setting cells for missed assessments.

Disenrollments

Continue to submit disenrollments as usual using reason codes 01 through 11. After HCFA processes the sites' last diskette, HCFA will globally assign a disenrollment date of 12/31/99 and a reason code designated for the demonstration end for those beneficiaries who have not been disenrolled for another reason.

Receipt of Final Data

March 15, 2000, will be the last day for HCFA to receive data (enrollments, reassessments, disenrollments, cell changes).

Receipt of Final Cost Report

A final cost report is due in HCFA by June 1, 2000.

Payments

Since October 1 is the last day we will accept new enrollments, October will also be the last month we will pay on an estimate of your enrollments. We need to hold back some payments until the monthly reconciliations and 1998/1999 Out-of-Plan adjustments are made. We suggest that your enrollment figures from now until October be as accurate as possible to avoid overpayments. We hope to complete the monthly reconciliations and the 1999 Out-of-Plan Adjustments by May 2000.

Personnel

Since we estimate May 2000 for HCFA to complete final processing of data and payments, we hope that appropriate staff will be retained to assist us until the end.

Recap of Timetable

September 15, 1999	Curtail marketing activities.
October 1, 1999	Last date to notify beneficiaries/contract providers of demonstration end date. Last day to accept new enrollments. Last month for receiving enrollment payments.
November 1999	No payment for enrollments; June 1999 reconciled. 1998 OOPS adjustment.
December 1999	No payment for enrollments; July 1999 reconciled.
December 1, 1999	Last day to accept reenrollments.
December 31, 1999	Last day for reassessments.
January 2000	August 1999 reconciled.
February 2000	September 1999 reconciled.
February 15, 2000	Last day for CNO contracted providers to submit bills to CNO.
March 2000	October 1999 reconciled.
March 15, 2000	Final receipt of data submitted to HCFA. HCFA globally assigns 12/31/99 disenrollment date and reason

code for beneficiaries not otherwise disenrolled.

April 2000	November 1999 reconciled.
May 2000	December 1999 reconciled. 1999 OOPS adjustment.
June 1, 2000	Cost Report due.

Please stick to the above dates and timelines as indicated. These timelines cannot be extended but tasks under them can be completed earlier. We appreciate all your hard work and effort in the CNO Demonstration over the last six years. Should you have questions, please contact me at (410) - 786-6654 or Sharon Norman at (410) - 786-6553.

Sincerely,

Thomas Theis
Project Officer

JIM RAMSTAD
HIRD DISTRICT, MINNESOTA

WAYS AND MEANS
COMMITTEE

TRADE SUBCOMMITTEE

HEALTH SUBCOMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515–2303

August 31, 1999

Mr. Mike Hash
Deputy Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building, Room 309-C
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Hash:

I recently introduced H.R. 1999, a bill to extend the Medicare Community Nursing Organization demonstrations for another three years. It builds on the language in the Balanced Budget Act, which I championed, to continue this effective and popular Medicare option. Just like last Congress, H.R. 1999 has garnered bipartisan support and I am optimistic about passing the bill this year.

As you know, all of the CNO sites received a letter dated July 19, 1999 outlining the time table for terminating the program. This current phase-down schedule will require current beneficiaries to voluntarily leave the program or not be reassessed by the four sites. This will also negatively impact the sites' ability to maintain their current nursing staff – the very nurses who have developed the key relationships with patients that make the program such a success.

That's why I am respectfully requesting HCFA to issue a revised disenrollment date of November 1, 1999. This date will allow Congress to complete its deliberations and reach a consensus on extending the CNO demonstrations. Should Congress not extend the demonstration authority, HCFA would still be able to terminate the programs by the scheduled date

Thank you for your attention and consideration of this request. I look forward to your timely response.

Sincerely,

JIM RAMSTAD
Member of Congress

PAUL D. WELLSTONE
MINNESOTA

Minnesota Toll Free Number
1-800-642-6041

United States Senate

WASHINGTON, DC 20510-2303

COMMITTEES:
LABOR AND HUMAN RESOURCES
SMALL BUSINESS
INDIAN AFFAIRS
VETERANS' AFFAIRS
FOREIGN RELATIONS

September 2, 1999

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Room 314-G
Washington, DC 20201

Dear Ms. Min DeParle:

As you may know, I recently introduced S. 1550, a bill to extend certain Medicare community nursing organization demonstration projects for an additional three years.

While there is significant bi-partisan support in Congress for extending the Community Nursing Organization (CNO) program beyond the current expiration date of December 31, 1999, I am concerned that the uncertainties about the continuation of the demonstration will soon affect day-to-day management and services provided to the Medicare beneficiaries enrolled in the four CNO programs.

It is quite possible that the CNO demonstration projects will not be extended until the final days of the first session of the 106th Congress, in late October or early November. Nonetheless, because of HCFA's proposed phase-down timetable, a significant number of Medicare beneficiaries will have either voluntarily left the program or not have been reassessed at the four sites as part of the phase-down process. Such uncertainty will negatively impact the sites' ability to maintain their current nursing staff, who have developed long-standing relationships with program participants.

Consequently, I am requesting that any notice of phase-down be delayed until the outcome of the legislative deliberations is known. Each CNO site received the enclosed communication from HCFA dated July 19, 1999, which outlines the timetable to be followed in the absence of enactment of legislation to extend the CNO programs. A revised disenrollment date of November 15, 1999, would allow Congress to complete deliberations and reach consensus on extending this important demonstration project.

I appreciate your prompt consideration and response to my concerns about the Medicare Community Nursing Organization demonstration projects.

Sincerely,

Paul D. Wellstone
United States Senator

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