Douglas P. DeMaster, Director, National Marine Mammal Laboratory, National Marine Fisheries Service, NOAA, 7600 Sand Point Way, NE, BIN C15700, Bldg. 1, Seattle, WA 98115–0070, has requested an amendment to scientific research Permit No. 782–1355.

DATES: Written or telefaxed comments must be received on or before August 17, 1998.

ADDRESSES: The application (File No. 481–1464), amendment request (Permit No. 782–1355), and related documents are available for review upon written request or by appointment in the following office(s):

Permits and Documentation Division, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13130, Silver Spring, MD 20910 (301/713–2289);

Regional Administrator, National Marine Fisheries Service, NOAA, Alaska Region, P.O. Box 21668, Juneau, AK 99802–1668 (907/586–7221).

Written comments or requests for a public hearing on this request should be submitted to the Chief, Permits and Documentation Division, F/PR1, Office of Protected Resources, NMFS, 1315 East-West Highway, Room 13130, Silver Spring, MD 20910. Those individuals requesting a hearing should set forth the specific reasons why a hearing on this particular amendment request would be appropriate.

Comments may also be submitted by facsimile at (301) 713–0376, provided the facsimile is confirmed by hard copy submitted by mail and postmarked no later than the closing date of the comment period. Please note that comments will not be accepted by e-mail or other electronic media.

FOR FURTHER INFORMATION CONTACT: Sara Shapiro or Ruth Johnson, 301/713–2289.

SUPPLEMENTARY INFORMATION: The subject permit application and amendment to Permit No. 782–1355, issued on July 15, 1997 (62 FR 39826) are requested under the authority of the Marine Mammal Protection Act of 1972, as amended (16 U.S.C. 1361 *et seq.*), the Regulations Governing the Taking and Importing of Marine Mammals (50 CFR part 216), the Endangered Species Act of 1973, as amended (ESA; 16 U.S.C. 1531 *et seq.*), and the regulations governing the taking, importing, and exporting of endangered fish and wildlife (50 CFR 222.23).

Dr. Richardson (File No. 481–1464) requests authorization to study the feeding ecology of bowhead whales in the eastern Alaskan Beaufort Sea through aerial surveys and sampling of prey species.

Permit No. 782–1355 authorizes the permit holder to take Pacific Harbor seals (*Phoca vitulina*) in the following manner: Harass during census flights; capture, restrain, measure (weight length, girth), sample (flipper punch, vibrissa, blood, blubber/muscle biopsy, ultra sound, enema), radio tag, flipper tag, and release 500 animals; and incidentally harass up to 2000 during the conduct of these activities, and during collection of scat samples from haulouts. The permit holder requests authorization to: increase the number of seals instrumented with time-depth recorders, biopsy sampled, and harassed.

In compliance with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), an initial determination has been made that the activities proposed are categorically excluded from the requirement to prepare an environmental assessment or environmental impact statement.

Concurrent with the publication of this notice in the **Federal Register**, NMFS is forwarding copies of this application to the Marine Mammal Commission and its Committee of Scientific Advisors.

Dated: July 7, 1998.

Ann D. Terbush,

Chief, Permits and Documentation Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 98–19122 Filed 7–16–98; 8:45 am]

BILLING CODE 3510–22–F

CONSUMER PRODUCT SAFETY COMMISSION

Sunshine Act Meeting

AGENCY: U.S. Consumer Product Safety Commission, Washington, DC 20207.

TIME AND DATE: Wednesday, July 22, 1998, 10:00 a.m.

LOCATION: Room 420, East West Towers, 4330 East West Highway, Bethesda, Maryland.

STATUS: Open to the Public.

MATTERS TO BE CONSIDERED:

FY 2000 Budget Request

The Commission will consider issues related to the Commission's budget for fiscal year 2000.

For a recorded message containing the latest agenda information, call (301) 504–0709.

CONTACT PERSON FOR ADDITIONAL INFORMATION: Sadye E. Dunn, Office of the Secretary, 4330 East West Highway, Bethesda, MD 20207 (301) 504–8000.

Dated: July 13, 1998.

Sadye E. Dunn,

Secretary.

[FR Doc. 98–19267 Filed 7–15–98; 2:48 pm]

BILLING CODE 6355–01–M

CONSUMER PRODUCT SAFETY COMMISSION

Sunshine Act Meeting

AGENCY: U.S. Consumer Product Safety Commission, Washington, DC 20207.

TIME AND DATE: Monday, July 27, 1998, 2:00 p.m.

LOCATION: Room 410, East West Towers, 4330 East West Highway, Bethesda, Maryland.

STATUS: Closed to the Public.

MATTERS TO BE CONSIDERED:

Compliance Status Report

The staff will brief the Commission on the status of various compliance matters.

For a recorded message containing the latest agenda information, call (301) 504–0709.

CONTACT PERSON FOR ADDITIONAL INFORMATION: Sadye E. Dunn, Office of the Secretary, 4330 East West Highway, Bethesda, MD 20207, (301) 504–0800.

Dated: July 14, 1998.

Sadye E. Dunn,

Secretary.

[FR Doc. 98–19268 Filed 7–15–98; 2:48 pm]

BILLING CODE 6355–01–M

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE Senior Demonstration of Military Managed Care

AGENCY: Office of the Assistant Secretary of Defense (Health Affairs).

ACTION: Notice of demonstration project.

SUMMARY: This notice is to advise interested parties of a demonstration project in which the Department of Defense (DoD) will provide health care services to Medicare-eligible military retirees in a managed care program, called TRICARE Senior, and receive reimbursement for such care from the Medicare Trust Fund. The program is authorized by section 1896 of the Social Security Act, amended by section 4015 of the Balanced Budget Act of 1997 (P.L. 105–33). The statute authorizes DoD and the Department of Health and Human Services (HHS) to conduct at six sites during January 1998 through December 2000, a three-year demonstration under which dual-eligible beneficiaries will be

offered enrollment in a DoD-operated managed care plan, called TRICARE Senior Prime. The legislation also authorizes Medicare HMOs to make payments to DoD for care provided to HMO enrollees by military treatment facilities (MTFs) participating in the demonstration. This part of the demonstration, to be called Medicare Partners, will allow DoD to enter into contracts with Medicare HMOs to provide specialty and inpatient care to dual-eligible beneficiaries currently provided on a space-available basis. Additional legal authority pertinent to this demonstration project is 10 U.S.C. section 1092.

Under TRICARE Senior Prime, Medicare-eligible military retirees who enroll in the program will be assigned primary care managers (PCMs) at the MTF. Enrollees will be referred to specialty care providers at the MTF and to participating members of the existing TRICARE Prime network. TRICARE Senior Prime enrollees will be afforded the same priority access to MTF care as military retiree and retiree family member enrollees in TRICARE Prime.

DoD will receive reimbursement from HCFA on a capitated basis at a rate which is 95 percent of the rate HCFA currently pays to Medicare-risk HMOs, less costs such as capital and graduate medical education, disproportionate share hospital payments, and some capital costs, which are already covered by DoD's annual appropriation. However, under the authorizing statute, DoD must meet its current level of effort for its Medicare-eligible beneficiaries before receiving payments from the Medicare Trust Fund. That is, DoD must continue to fund health care at a certain expenditure level for its Medicare-eligible population before it may be reimbursed by HCFA for care provided to TRICARE Senior Prime enrollees.

The Balanced Budget Act of 1997 required DoD and HHS to complete a memorandum of agreement (MOA) specifying the operational requirements of the demonstration project. That MOA was completed on February 13, 1998, and is published below. Except as provided in the MOA, TRICARE Senior Prime will be implemented consistent with applicable provisions of the CHAMPUS/TRICARE regulation, particularly 32 CFR sections 199.17 and 199.18.

EFFECTIVE DATE: July 15, 1998.

FOR FURTHER INFORMATION CONTACT: Larry Sobel, Office of the Assistant Secretary of Defense (Health Affairs/TRICARE Management Activity), telephone (703) 681–1742.

Dated: July 10, 1998.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

BILLING CODE 5000–04–P

MEDICARE DEMONSTRATION OF MILITARY MANAGED CARE

-- MEMORANDUM OF AGREEMENT --

The Department of Health and Human Services (DHHS), the Health Care Financing Administration (HCFA), the Department of Defense (DoD) and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) agree to conduct a demonstration project under which DHHS will reimburse DoD from the Medicare Trust Funds for certain health care services provided to Medicare-eligible military (dual-eligible) beneficiaries at a military treatment facility (MTF) or through contracts. This demonstration will be referred to as the TRICARE Senior Project.

TRICARE Senior will consist of two types of health care delivery systems: TRICARE Senior Prime and Medicare Partners. Under TRICARE Senior Prime, the Medicare program will treat the DoD and its Military Health System (MHS) similar to a Medicare+Choice plan for dual-eligible Medicare/DoD beneficiaries. Medicare will pay for dual-eligibles enrolled in the DoD managed care program after DoD meets its current level of effort, measured in terms of health care expenditures for the dual-eligible population. Under Medicare Partners, DoD will receive payment from Medicare+Choice plans under Part C of title XVIII of the Social Security Act with which DoD contracts for inpatient and physician specialty care services provided to Medicare-eligible military beneficiaries who are enrolled with the Medicare+Choice plans.

The goal of this demonstration is, through a joint effort by DHHS and DoD, to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency.

TERMS OF THE AGREEMENT

The Department of Health and Human Services and the Department of Defense agree to carry out a Medicare demonstration of military managed care under the following terms.

A. TRICARE SENIOR PRIME

1. LEGAL AUTHORITY

This demonstration project is conducted under the authority of section 1896 of the Social Security Act, as added by section 4015 of the Balanced Budget Act of 1997 (P.L. 105-33).

2. SITES SELECTED AND POPULATION COVERED

a) TRICARE Senior Prime will be offered at six sites: 1) Keesler Air Force Base, Biloxi, MS; 2) Wilford Hall Medical Center and Brooke Army Medical Center, San Antonio, TX; Fort Sill, Lawton OK; and Sheppard Air Force Base, Wichita Falls, TX; 3) Fort Carson and the Air Force Academy, Colorado Springs, CO; 4) Madigan Army Medical Center, Fort Lewis, WA; 5) Naval Medical Center San Diego, San Diego, CA; and 6) Dover Air Force Base, Dover, DE. For the purpose of this demonstration, the catchment areas for San Antonio, Fort Sill, and Sheppard Air Force Base will comprise one site.

b) Eligibility for participation in TRICARE Senior Prime consists of people who (during the demonstration):
- Are covered through Medicare's aged program by Medicare Part A and Medicare Part B and are eligible for care from DoD as described in section 1074(b) or 1076(b) of title 10 United States Code (i.e., the demonstration excludes Medicare beneficiaries who are disabled or eligible for ESRD benefits),
- Enroll in TRICARE Senior Prime,
- Agree to receive covered services through TRICARE,
- Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered, and
- Are a dual-eligible who, as a dual-eligible, used a Military Treatment Facility before January 1, 1998, or became dual-eligible starting after December 31, 1997.

c) Participation of Medicare-eligible military retirees or dependents in TRICARE Senior Prime shall be voluntary.

3. SERVICES COVERED AND PATIENT COPAYMENTS

Services covered include the standard Medicare benefit in addition to specific TRICARE Prime benefits. Specific benefits and patient copayments are defined in Attachment A -- "Benefits" to this final agreement as signed by the Secretaries. Patient copayments are also defined in Attachment A. TRICARE Senior Prime enrollees will not be charged a premium during the first year of the demonstration. DoD's intention is not to require a premium in the second or third years of the demonstration unless necessary to maintain cost neutrality. If DoD decides to require a premium, such premium will be subject to HCFA's Adjusted Community Rate (ACR) process.

4. SERVICES PROVIDED

The provision of services for those beneficiaries enrolled in TRICARE Senior Prime is the responsibility of DoD and services are either provided directly by DoD or arranged and paid for by DoD.

5. ENROLLMENT

a) DHHS authorizes DoD to enroll dual-eligible beneficiaries, using TRICARE Senior Prime, in the Medicare demonstration.

b) DoD will offer enrollment to dual-eligible beneficiaries eligible under this demonstration.
c) Enrollees must pay applicable cost sharing and agree that TRICARE Senior Prime will be the exclusive source of health care for enrolled beneficiaries. Beneficiaries who choose to enroll in TRICARE Senior Prime will be subject to all Medicare+Choice requirements, including the "lock-in" provision which prevents plan enrollees from using their fee-for-service Medicare benefits.

6. APPLICATION OF CONDITIONS OF PARTICIPATION APPLICABLE TO MEDICARE+CHOICE PLANS

DoD will meet the applicable requirements of a Medicare+Choice plan. The TRICARE Senior Prime requirements are defined in Attachment B of this agreement. The Secretary of DHHS may waive, to the extent authorized by section 1896(d) of the Social Security Act, the requirement or approve equivalent or alternative ways of meeting the requirement when it reflects the unique status of DoD and is necessary to carry out the demonstration of TRICARE Senior Prime. A description of the requirements waived under section 1896(d) appears at Attachment B.

The DoD and DHHS Secretaries certify that DoD has sufficient resources and expertise to provide, consistent with payments described in Paragraph 7 below, the full range of benefits required to be provided to beneficiaries under the project and sufficient information and billing systems in place to ensure the accurate and timely submission of claims for benefits and to ensure that providers of such services, physicians, and other health care professionals are reimbursed by the entity in a timely and accurate manner. Certification of individual sites will be subject to HCFA's approval process.

7. MEDICARE REIMBURSEMENT TO DOD

Medicare reimbursement and end-of-year reconciliation is based on the following provisions as defined further in Attachment C -- "Reimbursement"

a) Prior to being eligible for Medicare reimbursement under this demonstration in a given year, DoD will commit to the expenditure of resources for dual-eligible beneficiaries at a level that represents the DoD's FY96 level of effort at all demonstration sites.
b) Skilled nursing facility and home health costs, not a DoD benefit, paid by DoD for enrollees below the level of effort will be counted toward the level of effort.
c) For each demonstration year and each demonstration site, DoD and HCFA will establish a threshold for triggering interim payments during the demonstration year, expressed as a total annual dollar amount. That annual threshold will be 30 percent of the site's level of effort during the first demonstration year (pro-rated for the actual number of months of care delivery at each site), 40 percent during the second year, and 50 percent in the third. The total annual amount will be used to establish monthly dollar thresholds for triggering interim reimbursement. The monthly threshold at each site will be one-twelfth the annual threshold amount. For each demonstration month, HCFA will determine what it would pay each site for all enrollees, using the modified per capita reimbursement rates established by law. If HCFA's calculated amount exceeds

the monthly reimbursement threshold for a site, then HCFA will reimburse DoD for the amount over the threshold. If the amount that HCFA should pay the site is less than the monthly reimbursement threshold, then DoD will not receive any reimbursement for that site for that month. The reimbursement rate by Medicare to DoD is 95 percent of the applicable Medicare+Choice rate as determined under the Balanced Budget Act of 1997 (P.L. 105-33). In accordance with the authorizing legislation, the Medicare+Choice rate for each county will be adjusted to remove payments for graduate medical education (GME), indirect medical education (IME) and disproportionate share hospital (DSH). In accordance with the agreement by both Secretaries, 67 percent of capital payments will be removed. If requested by DoD and authorized by law, the Secretaries will reevaluate these latter adjustments based upon the recommendations of a demonstration evaluator or another public or private organization mutually acceptable to DHHS and DoD. Over the three years of the demonstration, the evaluation will track the rate and evaluate it against the primary goal of the demonstration.

d) As required by the Balanced Budget Act of 1997, the maximum total Medicare reimbursement to DoD from both Medicare and Medicare Partners for any demonstration year for all six demonstration sites will not exceed $50 million in the first year, $60 million in the second, and $65 million in the third. This is designed to avoid creating an artificial limitation on the demonstration and to limit the total risk to the Medicare Trust Fund. No more than 50 percent of the cap in each year shall be available for Medicare Partners. DoD will receive no payments after the maximum reimbursement amount has been reached in each demonstration year. For 1998, the $50 million ceiling shall be prorated based on the estimated enrollment at each site and the number of months that each site is operational during 1998. The ceiling for 1998 will be determined when the last site to begin in 1998 becomes operational.

e) At the end of each demonstration year, DHHS and DoD will conduct a reconciliation process. The purpose of the reconciliation is to determine whether DoD is entitled to retain reimbursements that they received under this demonstration and to determine the amount that they should retain. The reconciliation will not adjust for "underpayments" or "overpayments" that result from inefficiency or efficiency. The reconciliation process is described in detail in Attachment C: Reimbursement.

- If DoD and DHHS agree that favorable or adverse selection into the DoD plan is occurring, HCFA will recalculate what Medicare's payments should have been and adjust total payments accordingly, consistent with applicable law.
- If DoD received capitation payments from Medicare and its actual costs were less than the FY96 level of effort, DoD reimburses Medicare for all funds received under the demonstration project (TRICARE Senior Prime and Medicare Partners). For the purpose of this test, expenses for all six sites are combined and compared with a combined six-site level of effort. The contributions from individual sites toward total expenses include expenses for space available care and expenses for enrolled care. Expenses for space-available care for the demonstration-wide test will be capped at a limit that varies with demonstration year. The limit will be 70 percent of the combined six-site level of effort for the first demonstration year, 60 percent the second year, and 50 percent the third. The limit during the first year will be prorated for the months of care delivery at the various sites as described in Appendix C.

- To retain reimbursements received under the demonstration project, expenses for enrolled care, summed across all six demonstration sites, must meet or exceed a minimum threshold that varies with the demonstration year. The threshold is 30 percent of the combined six-site level of effort for the first demonstration year, 40 percent for the second year, and 50 percent for the third.
- HCFA auditors and the DHHS IG will have access to DoD's facilities and data. HCFA and DoD will develop a process for settling any disputes that arise over the data.
- DoD will submit encounter data to HCFA for all Medicare-covered services provided to TRICARE Senior Prime beneficiaries under the demonstration.

8. LEVEL OF EFFORT

a) For the purposes of this demonstration, DoD's level of effort at each site is the actual level of effort expended by DoD on dual-eligible beneficiaries for FY96. During the first demonstration year, this will be pro-rated at each demonstration site for the number of months of care delivery. That level of effort will remain constant for the three years of the demonstration except in the following instances: 1) If for the demonstration years, overall defense health spending (Category 3 of the Defense Health Program (See definition in "Level of Effort" attachment; currently about $12 billion)), updated with an annual adjustment by the applicable composite inflation rates, changes by more than $100 million, then DoD may adjust the level of effort at each site by a proportionate amount (e.g., if the budget is $400 million lower or higher, and defense health spending (Category 3) amounts to $12 billion, the level of effort will fall or rise by approximately 3.3 percent). 2) If there are any base realignment and closure (BRAC) actions that result in reductions in DoD's ability to serve dual-eligibles, an adjustment will be made in the level of effort so as to hold DoD harmless.

b) The FY96 level of effort for each site consists of expenses incurred against the Defense Health Program for services covered under the demonstration for dual-eligible beneficiaries who are eligible to enroll in the demonstration (as specified in "Sites Selected and Population Covered"). During each demonstration year, level of effort consists of the same expenditure categories plus care provided to enrollees (i.e., enrollees below level of effort) under the demonstration.

c) The methodology for computing the FY96 level of effort for each site is described in Attachment D -- "Level of Effort."

d) The FY96 level of effort for each site will:
   - Exclude outpatient pharmacy expenses and Uniformed Services Treatment Facilities costs.
   - Treat DoD collections from Medicare supplemental policies the same in both the baseline and the operational level of effort. Both agencies agree to reexamine this issue if there is a substantial change in collections during the demonstration.
   - Take a "Population View" (versus a "Facility View"), based on the population eligible to enroll in the demonstration as specified under "Population Covered."
   - Either include relevant "F" account costs from DoD's Medical Expense and Performance Reporting System (MEPRS) or directly adjust for the Institute for Defense Analysis (IDA) "add-on" factor, as specified in Attachment D. Over an

eighteen month period, DoD will validate IDA's findings regarding MEPRS cost factors and the size of the add-on factors.

e) For purposes of reconciliation, the test of whether DoD achieved its level of effort is conducted at a demonstration-wide level. The DoD's level of effort will be the sum of the six individual levels of effort.

9. PROHIBITION AGAINST INCREASING MEDICARE COST

The demonstration project shall not increase the total cost of the Medicare program over what the cost would have been in the absence of the demonstration. If the DoD or DHHS Secretaries find that the expenditures under the Medicare program increased (or are expected to increase) during a fiscal year because of the demonstration project, the Secretaries shall take such steps as may be needed to recoup for the Medicare program the amount of such increase in expenditures and to prevent any such increase in the future. Such steps shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds, the suspension or termination of the demonstration project (in whole or in part), or lowering the amount of payment to DoD.

10. JOINT ANALYSIS OF COST, UTILIZATION AND OTHER DATA

DHHS and DoD agree to carry out analyses of a merged data set of dual-eligibles based on questions (including utilization and cost prior to and during the demonstration) developed jointly by the two agencies. DHHS and DoD agree that the DHHS Secretary shall have access to all data the DHHS Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

11. EVALUATION

a) In addition to the General Accounting Office review referenced in Item 12 below, the demonstration shall be evaluated by an independent evaluator chosen jointly by DHHS and DoD, funded by DoD and in place as soon as possible following the start of the demonstration.

b) The evaluation contractor will produce an annual report, an interim report within 18 months of the initiation of this demonstration, and a final report not later than twelve months from the end of the demonstration. The evaluation will be based on the evaluation questions jointly developed by DHHS and DoD as illustrated in Attachment E – "Evaluation". Of those questions, the primary evaluation question will be "Can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries?" The evaluation will also emphasize the four major areas identified by DHHS and DoD in delineating the evaluation questions. The evaluation will also examine the impact of the demonstration on medical services for active duty and active duty dependents.

c) DHHS and DoD will provide the necessary data to support the evaluation.

12. GENERAL ACCOUNTING OFFICE STUDY

Section 1896(k) of the Social Security Act directs the General Accounting Office (GAO) to conduct a review and report to Congress as to whether or not the demonstration has increased the total cost of the Military Health System or the total cost of Medicare. Both agencies agree to jointly assist GAO with that review and report.

13. START DATE AND DURATION

The demonstration is authorized for three years and will end on December 31, 2000. Both Departments anticipate that the demonstration sites will become operational according to a phased schedule, to be published separately.

14. ADDITIONAL PROVISIONS

a) Military Treatment Facilities - No new military treatment facilities will be built and no existing facilities will be expanded with funds from the demonstration project.
b) Report - At least 60 days prior to the commencement of the demonstration project, the DoD and DHHS Secretaries shall submit a copy of this agreement to the Congressional committees of jurisdiction over the two departments.
c) Crediting of Payments - A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable DoD medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year in which the payment is received.
d) Inspector General - Nothing in this agreement shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of section 1896 of the Social Security Act and all other relevant laws.
e) Modification of TRICARE Contracts - In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts (including contracts with designated providers) in order to provide the Medicare health care services to the Medicare-eligible military retirees and dependents enrolled in the demonstration project consistent with Part C of title XVIII of the Social Security Act as amended by sec. 4001 of the Balanced Budget Act of 1997.
f) This MOA will be amended as necessary following the publication of regulations for Medicare+Choice plans.
g) All automated systems will comply with federal laws, guidances, and policies for information systems security. These include, but are not limited to, the Privacy Act of 1974, the Computer Security Act of 1987, IRM Circular #10, DHHS Automated Information Systems Security Program, the HCFA Information Systems Security Policy and Program Handbook, and other HCFA systems security policies. All information systems will have a security plan. This security plan will be developed during the systems development phase, in accordance with the mandates of the Office of Management and Budget's Circular A-130, revised.

B. MEDICARE PARTNERS

1. LEGAL AUTHORITY

This demonstration project is conducted under the authority of section 1896(h) of the Social Security Act, as added by section 4015 of the Balanced Budget Act of 1997 (P.L. 105-33).

2. POPULATION COVERED

a) All sites may conduct the Medicare Partners portion of the demonstration.
b) Eligibility for participation in Medicare Partners consists of people who (during the demonstration):
   - Are covered through Medicare's aged program by Medicare Part A and Medicare Part B and are eligible for care from DoD as described in section 1074(b) or 1076(b) of title 10 United States Code (i.e., the demonstration excludes Medicare beneficiaries who are disabled or eligible for ESRD benefits),
   - Are enrolled in a Medicare+Choice plan with which DoD has contracted,
   - Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered,
   - Are dual-eligible beneficiaries, who, as dual-eligibles, used a military treatment facility before January 1, 1998, or became dual-eligible starting after December 31, 1997, and
   - Agree to receive covered services through a Medicare+Choice plan and to use the MTF for covered services only as referred by a Medicare+Choice plan under contract with a demonstration site.
c) Participation of Medicare-eligible military retirees or dependents in Medicare Partners shall be voluntary.

3. SERVICES COVERED UNDER MEDICARE+CHOICE PLAN CONTRACTS WITH DOD

a) Medicare+Choice plans are authorized to contract with and reimburse DoD for inpatient and physician specialty care services provided to dual-eligible beneficiaries. To the extent feasible and subject to capacity constraints, DoD may contract with Medicare+Choice plans which meet applicable HCFA requirements. DoD and HCFA will review and approve all MTF agreements with Medicare+Choice plans. Services covered include those inpatient and physician specialty care services for which DoD has contracted with the Medicare+Choice plan.
b) Priority access for dual-eligibles to the MTF shall apply only to those services for which the participating Medicare+Choice plan has contracted with DoD and is subject to the availability of resources at the MTF. Priority access to the MTF for contracted services shall be the same for Medicare Partners enrollees as for CHAMPUS-eligible retirees enrolled in TRICARE Prime.

4. SERVICES PROVIDED

The provision of services for beneficiaries enrolled in a Medicare Partners plan is the responsibility of the participating plan in which the beneficiary has enrolled. MTFs in the demonstration sites will provide services to Medicare Partners enrollees according to the terms of the contracts reached between the participating Medicare+Choice plans and the MTFs.

5. ENROLLMENT

a) Dual-eligible beneficiaries may enroll in a Medicare+Choice plan which has a Medicare Partners agreement with DoD according to the procedures established by the plan in compliance with HCFA requirements.
b) DoD shall establish procedures to identify in its own data systems enrollees in a Medicare Partners plan.
c) Supplemental or modified marketing materials produced by a Medicare Partners plan in connection with services offered to dual-eligible enrollees shall be reviewed and approved by DoD and HCFA.

6. APPLICATION OF CONDITIONS OF PARTICIPATION APPLICABLE TO MEDICARE+CHOICE PLAN PROVIDERS

DoD will meet the applicable requirements, except as waived by HCFA, of a contract health care provider to a Medicare+Choice plan.

7. REIMBURSEMENT

Reimbursements under Medicare Partners contracts will be specific to each agreement and subject to approval by DoD and HCFA as specified in Section B, paragraph 3a. All reimbursements from Medicare Partners count toward the annual maximum reimbursement described in Section A, paragraph 7.d). No more than 50 percent of the cap in each year shall be available for Medicare Partners. The method for determining the amount of Medicare Partners reimbursement retained by DoD or returned to HCFA is described in Attachment C. To the extent feasible, the portion of DoD reimbursement from Medicare Partners attributable to graduate medical education, indirect medical education, disproportionate share, and capital, for which DoD has received appropriated funds and which has been included in HCFA's payment to the Medicare+Choice plan, will be identified and returned to HCFA as part of the annual reconciliation process.

8. LEVEL OF EFFORT

Any costs arising from services provided under Medicare Partners will not count toward the demonstration's total level of effort. In addition, DoD will not retain any reimbursement for Medicare Partners unless it exceeds the demonstration's total level of effort.

9. PROHIBITION AGAINST INCREASING MEDICARE COST

The demonstration project shall not increase the total cost of the Medicare program over what the cost would have been in the absence of the demonstration. If the DoD or DHHS Secretaries find that the expenditures under the Medicare program increased (or are expected to increase) during a fiscal year because of the demonstration project, the Secretaries shall take such steps as may be needed to recoup for the Medicare program the amount of such increase in expenditures and to prevent any such increase in the future. Such steps shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds, the suspension or termination of the demonstration project (in whole or in part), or lowering the amount of payment to DoD.

10. JOINT ANALYSIS OF COST, UTILIZATION, AND OTHER DATA

DHHS and DoD agree to carry out analyses of a merged data set of dual-eligibles based on questions (including utilization and cost prior to and during the demonstration) developed jointly by the two agencies. DHHS and DoD agree that the DHHS Secretary shall have access to all data the DHHS Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project.

11. EVALUATION

a) In addition to the General Accounting Office review referenced in Item 12 below, the demonstration shall be evaluated by an independent evaluator chosen jointly by DHHS and DoD, funded by DoD and in place as soon as possible following the start of the demonstration.
b) The evaluation contractor will produce an annual report, an interim report within 18 months of the initiation of this demonstration, and a final report not later than twelve months from the end of the demonstration. The evaluation will be based on the evaluation questions jointly developed by DHHS and DoD as illustrated in Attachment E -- "Evaluation". Of those questions, the primary evaluation question will be "Can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries?" The evaluation will also emphasize the four major areas identified by DHHS and DoD in delineating the evaluation questions. The evaluation will also examine the impact of the demonstration on medical services for active duty and active duty dependents.
c) DHHS and DoD will provide the necessary data to support the evaluation.

12. GENERAL ACCOUNTING OFFICE STUDY

Section 1896(k) of the Social Security Act, directs the General Accounting Office (GAO) to conduct a review and report to Congress as to whether or not the demonstration has increased the total cost of the Military Health System or the total cost of Medicare. Both agencies agree to jointly assist GAO with that review and report.

13. START DATE AND DURATION

The demonstration is authorized for three years and will end on December 31, 2000. Both Departments anticipate that Medicare Partners sites will become operational no earlier than 90 days after the start of health care delivery under TRICARE Senior Prime at that site, subject to the satisfactory progress of the TRICARE Senior Prime program as demonstrated through meeting the requirements of Attachment F- "Performance Measures" and evidence that adequate financial systems to track level of effort and reimbursement are in place.

14. ADDITIONAL PROVISIONS

a) Military Treatment Facilities - No new military treatment facilities will be built and no existing facilities will be expanded with funds from the demonstration project.
b) Report - At least 60 days prior to the commencement of the demonstration project, the DoD and DHHS Secretaries shall submit a copy of this agreement to the Congressional committees of jurisdiction over the two departments.
c) Crediting of Payments - A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable DoD medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year in which the payment is received.
d) Inspector General - Nothing in this agreement shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of section 1896 of the Social Security Act and all other relevant laws.
e) All automated systems will comply with federal laws, guidances, and policies for information systems security. These include, but are not limited to, the Privacy Act of 1974, the Computer Security Act of 1987, IRM Circular #10, DHHS Automated Information Systems Security Program, the HCFA Information Systems Security Policy and Program Handbook, and other HCFA systems security policies. All information systems will have a security plan. This security plan will be developed during the systems development phase, in accordance with the mandates of the Office of Management and Budget's Circular A-130, revised.

C. ATTACHMENTS

Included as part of this agreement are the following items:

Attachment A: Benefits under TRICARE Senior Prime
Attachment B: Applicable Conditions of Participation under TRICARE Senior Prime
Attachment C: Reimbursement
Attachment D: Level of Effort
Attachment E: Evaluation

Attachment F: Performance Measures

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Attachment A—Benefits for Enrollees; Medicare Demonstration of Military Managed Care

DoD will provide or arrange for the provision of a defined benefit package for enrollees in the Demonstration. The benefit package will include all services and supplies covered by the Medicare program, plus some additional services not covered by Medicare. The TRICARE Prime program will be the vehicle for delivery of the benefit package, except that standard Medicare coverage of skilled nursing facility care, home health care, and chiropractic services will apply. Additional services in the TRICARE Prime program that are not covered by Medicare include outpatient pharmacy services and preventive services. In brief, the benefit package includes coverage of medically necessary care as follows:

Medical Services

- Physician's services;
- Medical and surgical services and supplies;
- Outpatient hospital treatment;
- Mental health outpatient services;
- Physical and speech therapy;
- Clinical laboratory services and diagnostic tests;
- Durable medical equipment and supplies;
- Blood;
- Clinical preventive services;
- Outpatient pharmacy services.

Institutional Services

- Hospitalization: semiprivate room and board, general nursing and other hospital services and supplies;
- Skilled nursing facility care: semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies;
- Home health care;
- Hospice care.

Cost sharing for services is described in the attached charts. It is anticipated that most services will be provided in military treatment facilities, at no charge to enrollees. When enrollees use a civilian provider, a copayment schedule will apply, featuring a $12 per visit copayment, an $11 per diem charge for most inpatient services, and a $9 per prescription charge.

Attachment A

BENEFITS FOR PRIME-ENROLLED MEDICARE ELIGIBLES: - MEDICAL INSURANCE SERVICES

SERVICES	BENEFIT	YOU PAY WITH CIVILIAN PROVIDER	YOU PAY AT MTF
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and other services.	Unlimited if medically necessary.	$12 per visit (or $12 each for bills from separate entities coincident to a visit).	Nothing.
MENTAL HEALTH OUTPATIENT	Unlimited if medically necessary.	$25 per visit	Services not normally available at MTF
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	$12 per set of lab services (Nothing if provided as part of an office visit).	Nothing.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES	Unlimited as long as you meet Medicare conditions.	20% of fee negotiated by the contractor for durable medical equipment.	Nothing; however availability may be limited at MTF.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	$30 for emergency room visit (waived if admitted), $25 copayment for ambulatory surgery.	Nothing.
BLOOD	Unlimited if medically necessary.	No additional cost beyond visit.	Nothing.
PHARMACY	Unlimited if medically necessary.	$9 per prescription.	Nothing.
CLINICAL PREVENTIVE SERVICES Comprehensive and targeted health promotion and disease prevention examinations and immunizations.	Age specific schedule to be determined, similar to Prime for younger enrollees	Nothing.	Nothing.
No separate copayment/cost share for separately billed inpatient professional charges.			

Attachment A

BENEFITS FOR PRIME-ENROLLED MEDICARE ELIGIBLES: HOSPITAL INSURANCE SERVICES

SERVICES	BENEFIT	YOU PAY WITH CIVILIAN PROVIDER	YOU PAY AT MTF
HOSPITALIZATION (except mental health) Semiprivate room and board, general nursing and other hospital services and supplies.	Same as Medicare	$11 a day ($25 minimum).	Nothing.
MENTAL HEALTH HOSPITALIZATION	Same as Medicare 150 day limit per hospitalization	$40 per diem	Inpatient mental health services not normally available at MTF.
SKILLED NURSING FACILITY Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies.	First 20 days Additional 80 days Beyond 100 days	Same as Medicare: Nothing Up to $95 a day All costs	Services not normally available at MTF.
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services.	Unlimited as long as you meet Medicare conditions.	Same as Medicare: Nothing for services.	Services not normally available at MTF.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	As long as doctor certifies need.	Same as Medicare for inpatient respite care: Limited costs. For outpatient drugs: $9 prescription.	Services not normally available at MTF.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited if medically necessary.	No additional cost beyond hospitalization.	No additional cost beyond hospitalization.
No separate copayment/cost share for separately billed inpatient professional charges.			

Attachment B

Medicare Demonstration of Military Managed Care
Attachment B -- HCFA HMO Requirements
(Applicable Conditions of Participation)

ADMINISTRATIVE AND MANAGEMENT

HCFA Requirement:	Determination:
1. The HMO/CMP must have administrative and managerial arrangements satisfactory to HCFA, as demonstrated by at least the following: A policy making body that exercises control over the HMO/CMP's policies and personnel to ensure that management actions are in the best interest of the HMO/CMP and its enrollees. **42CFR417.124(a)(1)**	General policy is established at the DoD level by the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the respective services. Policy is conveyed through the services to the Lead Agent to the Military Medical Treatment Facility (MTF). At the MTF level, and as delegated by the Surgeons General, the MTF Commander executes DoD policy and may establish additional policy for administration and operation of the facility. The Commander and MTF Executive Body (management, department, medical staff, nursing) plan, direct, coordinate, provide and improve health care services. MTF Commanders are active duty officers whose appointment and removal are under the control of the Service to which they belong and the Surgeon General. The Commander, Executive Body, and other organizational leaders meet routinely to provide organization, direction, and staffing for patient care and support services. Information flows within and among departments and disciplines to ensure that required data are provided efficiently for patient care and management at all levels. DoD will meet requirements for ensuring that staff and management are adequately informed and following program requirements. The MTFs will provide training to staff and providers regarding the Medicare product. New or revised Medicare requirements will be disseminated as revisions to the manual through Health Affairs to the Lead Agent.
2. The HMO\CMP has personnel and systems sufficient for the HMO/CMP to organize, plan, control, and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the HMO/CMP. **42CFR417.124(a)(2)**	These requirements are fulfilled through a collaborative process of support from specific offices within Health Affairs, the Lead Agent, and the Military Treatment Facilities (MTFs).

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HCFA Requirement:	**Determination**
3. The HMO/CMP's operations are managed by an executive whose appointment and removal are under the control of the HMO/CMP policymaking body. **42CFR417.124(a)(3)**	The Lead Agent is responsible for the integration, coordination and monitoring the implementation of TRICARE within the Region. Local operation of the Medicare demonstration will be the responsibility of the MTF Commanders. MTF Commanders are active duty officers whose appointment and removal are under the command and control of the Service to which they belong and the Surgeon General.
4. The HMO/CMP has effective procedures to develop, compile, evaluate, and report statistical and other information to the Secretary of DHHS. **42CFR417.126**	DoD provides support for the demonstration at every level, including a management information system capable of providing appropriate information. DoD's Corporate Executive Information Center (CEIS) is the center of the data collection effort and is our official source of demonstration data. The CEIS Program Office is staffed with experts that have the ability to develop, compile, evaluate, and report statistical and other information to the Secretary of DHHS.
5. The HMO/CMP has sufficient administrative capability to carry out the requirements of its Medicare contract. **42CFR417.412(a)**	Internal policy and procedures manual relative to the Medicare product will be available within the MTF. Staff and providers are provided informational materials and training in Medicare requirements such as denials and appeals. Health Affairs, through the Lead Agent, provides information to MTFs on any new or revised Medicare requirement. The MTF provides updates to staff and providers.
6. The HMO/CMP does not have any agents or management staff or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Act. **42CFR417.412(b)**	DoD health care facilities are government owned. DoD's personnel policies prohibit the continued employment in health care programs of an individual convicted of a criminal offense involving any other health care program.
7. Medicare/Medicaid enrollees do not exceed 50 percent of the HMO/CMP enrollment in the geographic area of the contract. **42CFR417.413(d)(1)**	TRICARE Prime enrollment levels are sufficient to ensure DoD compliance with this requirement.

Attachment B

HCFA Requirement:	Determination:
8. Regarding the Patient Self Determination Act, the HMO/CMP has written policies and procedures which: 1) inform enrollees of their rights under State law with respect to advance directives (living wills/durable power of attorney), and how those rights are implemented: 2) documented in the medical record whether or not the enrollee has executed an advance directive: 3) ensure compliance with State law; 4) do not condition provision of care/or discriminate on whether enrollee has executed advance directive; and 5) provide for education of staff/community regarding advance directive. **OBRA 1990 (PL 101-508)**	MTFs meet JCAHO standards for Patient Rights and Organization Ethics in both hospital and ambulatory settings. MTFs have policy regarding advance directives and a process to educate staff. MTFs will provide education on the PSDA to enrollees and staff members through marketing and education programs. Documentation requirements of the existence of living wills or durable power of attorney will be met during the enrollment process and upon each inpatient admission.

FISCAL SOUNDNESS

HCFA Requirement:	Determination:
9. The HMO/CMP's most recent balance sheet reveals a positive net worth as demonstrated by total assets being greater than total unsubordinated liabilities. **42CFR417.120(a)(1)(i)**	Not applicable.
10. The HMO/CMP has sufficient cash and adequate liquidity to meet obligations as they become due. **42CFR417.120(a)(1)(ii)**	Not applicable.

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HCFA Requirement:	**Determination:**
11 The HMO/CMP has a net operating surplus, or a financial plan acceptable to Office of Managed Care (OMC), to achieve net operating surplus within available resources. **42CFR417.120(a)(1)(iii)**	Not applicable.

INSOLVENCY PROTECTION PLAN

HCFA Requirement:	**Determination:**
12. The HMO/CMP has a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which payment has been made and continuation of benefits to enrollees who are confined on the date of insolvency in an inpatient facility until their discharge. **42CFR417.120(a)(1)(iv), 417.122(a)**	All obligations are backed by the full faith and credit of the Department of Defense. Where DoD uses contracted providers to complete their networks, those contracts will include standard NAIC-approved hold harmless language. Also, DoD will demonstrate compliance with the requirements for continuation of benefits in these arrangements.

Attachment B

COST REPORTING/ADJUSTED COMMUNITY RATE
Risk Based Contractors

HCFA Requirement:	Determination:
13 The HMO/CMP submits an ACR proposal to HCFA for review and approval. **42CFR417.594**	DoD will submit an ACR proposal for each site, prepared on a consistent basis, for HCFA review and approval.

UTILIZATION MANAGEMENT (UM)

HCFA Requirement:	Determination:
14. The HMO/CMP has effective procedures to monitor utilization of appropriate health services and to control costs of basic and supplemental health services to achieve utilization goals. **42CFR417.103(b)**	DoD will meet these requirements through the integration of the Medicare HMO enrollees into TRICARE, DoD's managed care program. The MTF will apply the same utilization and access process applicable under TRICARE, the DoD Utilization Management Policy for the Direct Care System, to the Medicare demonstration, including use of a single point of entry for all referrals. Routine referral reports are monitored by the MTF and LA.

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INCENTIVE ARRANGEMENTS

HCFA Requirement:	**Determination:**
15. The HMO/CMP will disclose physician incentive plan arrangements. **42CFR417.479**	DoD will disclose physician incentive plan (PIP) arrangements using the HCFA disclosure form as required for all Medicare contractors. This includes disclosure of MTF-salaried physicians and arrangements with outside contractors.

HEALTH SERVICES DELIVERY SYSTEM

HCFA Requirement:	**Determination:**
16. The HMO/CMP arranges for required Medicare services, and supplemental services which the Medicare enrollee has contracted for through Medicare-approved providers and suppliers. **42CFR417.101(a), 417.416(b)**	MTFs will provide the majority of health care services directly, either in the MTF or in the network of providers in place for their other TRICARE enrollees (to the extent that required services are available from Medicare certified providers within the network). For services not available within the network, the MTF through the Managed Care Support contractor, will arrange for services from other Medicare certified providers in the community. - Criteria for Selection of Network Providers).
17. HMO/CMP physicians and other practitioners must meet Medicare statutory definitions and licensure requirements. **42CFR417.416(a)**	Only licensed physicians and other practitioners who are legally authorized to provide services (physical therapists, nurse practitioners, physician assistants, clinical social workers, qualified psychologists, speech-language pathologists, etc.) will participate in this demonstration. However, DoD does not require physicians and other practitioners to be licensed or legally authorized in the State in which they currently practice. Compliance with this requirement is not feasible because DoD's unique mission of rapid deployment and backfill worldwide would be significantly hampered by this requirement. Under the authority of section 1896(d)(1) of the Social Security Act, waivers of sections 1861(r), 1861(p)(4)(B), 1861(aa)(5), 1861(gg)(1), 1861(hh)(1)(C)(i), 1861(ii), and 1861(ll)(3)(A)(i) of the Social Security Act are granted except that physicians and other practitioners must be licensed or

Attachment B

	legally authorized to provide services in at least one State.
18. Institutional providers are Medicare-certified and meet conditions of participation. **42CFR417.124(h), 417.416(b)**	Participating MTFs will be deemed to meet the conditions of participation since they are JCAHO accredited. Inpatient care not provided at the MTF will be through TRICARE network institutional providers that are Medicare certified providers.

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AVAILABILITY AND ACCESSIBILITY OF SERVICES

HCFA Requirement:	**Determination:**
19. All required and other services which Medicare enrollees contracted for are accessible, with reasonable promptness, to the enrollees with respect to geographic location, hours of operation, and provision of after-hours service; and, medically necessary emergency services must be available twenty-four hours a day, seven days a week. **42CFR417.106(b), 417.416(e)(1), HMO Manual §2303.**	As a general rule, DoD will utilize the same access standards that apply for TRICARE Prime for TRICARE Senior Prime, e.g., emergency services available and accessible within the service area 24 hours a day, 7 days a week, no more than 30 minute wait time in the office, appointment wait time for specialty care is no longer than 4 weeks, beneficiary travel time to PCM is no longer than 30 minutes, etc. Specific service area information will be provided as part of the application process. Enrollees will be informed through the Member Handbook. However, DoD's policy for access to a MTF has traditionally been a 40-mile area around the MTF. Historically, beneficiaries residing within that 40-mile area have been required to obtain a non-availability statement from the MTF in order to access the civilian provider community for many health care services. DoD will use this same area as the service area. Enrollees will be informed about HCFA's 30-minute/30-mile PCM access standard, and DoD will obtain waivers of this standard from enrollees who reside beyond the 30-minute/30-mile boundary.

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MAINTENANCE OF MEDICAL RECORDS AND CONTINUITY OF CARE

HCFA Requirement:	Determination:
20. The HMO/CMP ensures continuity of care through arrangements that include: (1) use of a health professional who is primarily responsible for coordinating the enrollee's overall health care; (2) a system of health and medical records that accumulates pertinent information about the enrollee's health care and makes it available to appropriate professionals; and (3) arrangements made directly through the HMO/CMP's providers to ensure that the HMO/CMP or the health professional who coordinates the enrollee's overall health care is kept informed about the services that the referral resources furnish to the enrollee. **42CFR417.106(c), 42CFR417.416(e)(2)**	DoD will meet this requirement. DoD's plans for meeting this requirement will be described more fully in its application to HCFA.

QUALITY ASSURANCE (QA) (ASSESSMENT AND IMPROVEMENT)

***Denotes critical element - an element that the HMO/CMP must meet.**

HCFA Requirement:	Determination:
21. The HMO/CMP has an ongoing QA program for its health services that meets the conditions described in: QA01a; QA01b, QA01c; QA01e; and QA01f, below. QA01a: Written QA Plan QA01b: Continuous QA Activities QA01c: Review by Board of Directors QA01d: Delegation of QA functions QA01e: Active QA Committee QA01f: Systematic Process.	DoD has a corporate program for ensuring quality of care in the MHSS which addresses all of the HCFA critical elements listed above. In addition, each site has a QA program which satisfies HCFA requirements.

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QA PROGRAM STRESSES HEALTH OUTCOMES

HCFA Requirements:	**Determination:**
22. The HMO/CMP's ongoing QA program for its health services stresses health outcomes to the extent consistent with the state of the art. **42 CFR 417.106(a)(1) and 417.418(b); FQ HMO Manual § 4200, 4201.2**	The DoD QA program meets the requirements of this section through the special studies component of the National Quality Management Program. The studies emphasize best practice. Best practice is achieving the desired clinical outcomes with the most efficient use of resources. May also be found on the World Wide Web (http://www.ha.osd.mil).

PEER REVIEW

HCFA Requirements:	**Determination:**
23. The HMO/CMP's ongoing QA health services review program provides for review by physicians and other health professionals of the process followed in the provision of health services. **42 CFR 417.106(a)(2) and 417.418(b); FQ HMO Manual § 4201, 4201.3**	The DoD requires that all of the military hospitals and clinics and all civilian network hospitals be accredited by the Joint Commission on Health Care Organizations (JCAHO). The JCAHO standards for medical staff functions and improving organization function require physician and other health care practitioner review of care. In addition, the special studies discussed above are designed by physicians and other health care practitioners and final reports are used by the hospitals and clinics to catalyze a review and improvement of their care.

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SYSTEMATIC DATA COLLECTION

HCFA Requirements:	Determination:
24. The HMO/CMP's ongoing health services QA program systematically collects performance data and patient results, interprets these data to its practitioners, and institute needed change. **42 CFR 417.106(a)(3) and 417.418(b); FQ HMO Manual § 4201, 4201.4**	These data are collected and reviewed at the Lead Agent and MTF levels. The MTFs are supported by MCS contractor data collection and analysis of the appropriateness of the care provided to beneficiaries. In addition, the MCS contractor performs regional quality studies over the term of the contract. The National Quality Monitoring Program special studies include all care provided by the military facilities and civilian network facilities.

REMEDIAL ACTION (CONTINUOUS QUALITY IMPROVEMENT)

HCFA Requirements:	Determination:
25. The HMO/CMP's ongoing QA program for its health services includes written procedures for taking appropriate remedial action whenever, as determined under the QA program, either inappropriate or substandard services have been provided or services which it should have furnished but did not provide. **42 CFR 417.106(a)(4) and 417.418(b); FQ HMO Manual § 4201, 4201.5**	DoD will meet HCFA's requirements for an ongoing QA program.

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EXTERNAL REVIEW BY PEER REVIEW ORGANIZATION (PRO)

HCFA Requirements:	**Determination:**
26. Compliance with PRO Review. The HMO/CMP agrees to: (1) comply with the requirements for PRO review of services furnished to Medicare enrollees: (2) upon the PRO's request, provide onsite access to or copies of medical records for the PRO to carry out its functions; and (3) maintain a written Memorandum of Understanding (MOU) he PRO for review of its health care services.	The MTF will execute a MOU with the designated HCFA PRO and comply with these requirements.

MARKETING ACTIVITIES

HCFA Requirements:	**Determination:**
27. The HMO/CMP offers its benefit plan to all Medicare-beneficiaries and provides prospective enrollees adequate written description of its rules, procedures, benefits, and other charges, services, and other necessary information for the beneficiary to make an informed decision about enrollment. **42 CFR 417.428(a) (1)**	Marketing materials will be developed centrally within Health Affairs with site specific information and will clearly describe the benefit plan, rules, procedures, charges, etc. DoD will submit marketing materials to HCFA for review and approval. Approved materials will be provided to prospective enrollees on enrollment and updated annually.
28. The HMO/CMP publicizes the annual open season and all enrollment periods, whether of limited or continuous duration, through appropriate media. The HMO/CMP has at least one continuous 30-day open enrollment period annually. **42 CFR 417.428(a) (2) and 42 CFR 417.426(a)**	DoD will market to Medicare eligible MHSS beneficiaries within the catchment area of participating MTFs. DoD will conduct a 30 day open enrollment season annually. Enrollment will be continuous for applicants on the waiting list as space becomes available through attrition.
29. The HMO/CMP provides a written copy of the most current member rights to the enrollee at the time of enrollment and annually thereafter. **42 CFR417.436(a) and (b)**	DoD will meet this requirement.

Attachment B

HCFA Requirement:	Determination:
30. Application forms are submitted to HCFA for approval prior to use and comply with HCFA instructions regarding format and content. **42 CFR 417.430(a); HMO Manual § 2001.5 and Exhibit 1, §2099.**	DoD will meet this requirement.

PROHIBITED MARKETING ACTIVITIES

HCFA Requirement:	Determination:
31. In offering its HMO/CMP to Medicare beneficiaries, the HMO/CMP does not engage in discriminatory practices including attempts to discourage participation on the bases of age, race, or attempt to enroll persons from a high income area if a comparable effort is not made to enroll persons from lower income areas. **42 CFR 417.428(b) (1)**	DoD will meet this requirement.
32. The HMO/CMP does not engage in activities which mislead, confuse, or misinterpret (e.g., HMO/CMP may not claim recommendation or endorsement by HCFA or that HCFA recommends that the person enroll in the organization; HMO/CMP may not make erroneous written or oral statement including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in HCFA-approved materials) **42 CFR 417.428(b) (2)**	DoD will meet this requirement.
33. The HMO/CMP does not offer gift or payment as an inducement to enroll in the organization. **42 CFR 417.428(b) (3)**	DoD will meet this requirement.
34. The HMO/CMP does not conduct door to door solicitation of Medicare beneficiaries. **42 CFR 417.428(b) (4)**	DoD will meet this requirement.

Attachment B

HCFA Requirement:	**Determination:**
35. The HMO/CMP submits all Medicare marketing materials (e.g., ads, brochures, enrollments and disenrollment notices, subscriber agreements, and other marketing material including those prepared by contracting third parties) to HCFA at least 45 days before their planned distribution. **42 CFR 417.428(a) (3)**	DoD will submit Medicare marketing materials to HCFA at least 45 days before their planned distribution.
36. The HMO/CMP does not distribute Medicare marketing materials if, before the expiration of the 45 day period, it receives written notice from HCFA has disapproved the materials because it is inaccurate or misleading or it misrepresent the organization, its marketing representative or HCFA. **42 CFR 417.428(b) (5)**	DoD will meet this requirement.
37. The HMO/CMP only charges Medicare members for deductible and coinsurance amounts (as describe in 42 CFR 417.452(b)); for furnished covered services; noncovered services or services for which the enrollee is liable (as describe in 42 CFR 417.452(b)); and services for which Medicare is not the primary payer (as provided in 42 CFR 417.528). **42 CFR 417.454(a).**	DoD will meet this requirement.
38. If the HMO/CMP offers its Medicare enrollees an optional supplemental benefit plan which includes charges for deductible and coinsurance amounts, or noncovered services, or both, then the portion of the premium for coinsurance and deductibles applicable to covered services is computed separately and is disclosed to the Medicare beneficiary/applicant before he or she elects coverage options. The sum of the amounts the HMO/CMP charges its Medicare enrollees for noncovered services under Part A or Part B may not exceed the ACR as annually approved by HCFA. **42 CFR 417.452(d)**	DoD offer the TRICARE Prime benefit package to demonstration enrollees, plus specific Medicare services not covered by Prime, i.e., chiropractic services. If DoD offers non-Medicare covered. services through an optional supplemental benefit plan, then DoD will meet this requirement.

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APPLICATIONS AND ENROLLMENT
ELIGIBILITY TO ENROLL

HCFA Requirements:	Determination:
39. The HMO/CMP does not deny enrollment on the basis of health status except for ESRD or hospice care election in a Medicare-certified hospice (unless subject to 42CFR417.432 conversions). **42 CFR417.422(b) and HMO Manual 2003.1**	Enrollment personnel have been instructed that applicants will not be denied enrollment on the basis of health status except for ESRD or hospice care election in a Medicare-certified hospice.

APPLICATION FORMS

HCFA Requirements:	Determination:
40. Applications are signed and dated by the enrollee. **42 CFR 417.430(a) HMO Manual 2001.5C**	DoD will meet this requirement. Applications will not be considered completed without the applicant's signature and the date the application was completed.
41. Applications are on file for all current enrollees and are kept for at least one year following an enrollee's disenrollment. **42 CFR 417.430(a)(2); HMO Manual 2001.5C**	DoD will meet this requirement. Completed applications will be retained on file for a minimum of one year.
42. Applicants are given an opportunity to acknowledge that they understand the HMO/CMP's rules and agree to abide by them. **42 CFR 417.422(e); HMO Manual 2001.5C**	DoD will meet this requirement. DoD will provide information to prospective enrollees on the HMO rules. When applicants arrive to complete the application form, the rules will be explained and the applicant will be afforded the opportunity to ask questions about the program. Prior to completing the application, the applicant will certify that they understand and will abide by the rules. Applicants who mail in applications will be contacted by telephone to ensure understanding of the program.

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HCFA Requirements:	**Determination:**
43. Applicants are informed (through the application process or pre-enrollment marketing information) that their enrollment will result in disenrollment from another HMO/CMPs Medicare product if they are currently enrolled in another HMO/CMP. **42 CFR 417.422(c); HMO Manual § 2001.5C**	DoD will meet this requirement. The application forms will include a section that explains that enrollment in DoD's HMO will result in disenrollment from other HMO/CMPs Medicare products. Applicants will certify that they understand.

ENROLLMENT PROCEDURES

HCFA Requirements:	**Determination**
44. The HMO/CMP has an effective system in place for receiving, controlling, and processing applications from Medicare enrollees. Applications are dated as of date they are received by the HMO/CMP. Applications are processed in chronological order by date of receipt **42 CFR 417.430(b), (b) (1) and (b) (2); HMO Manual § 2001.6**	DoD will meet this requirement. Applications will be dated , given sequential numbers and processed in the order that they are received.
45. The HMO/CMP notifies the applicant in writing of receipt and/or denial prior to processing. if appropriate, of the application no later than 30 days following receipt of the application. The written notice of receipt specifies the proposed effective date of enrollment; or, if the HMO/CMP is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur. **42 CFR 417.430(b)(3); (b) (4)(i) and (ii); HMO Manual § 2001.6.**	DoD will meet this requirement. DoD will confirm the information on the enrollment form through telephonic interviews and offer in-person interviews. All applicants whose enrollment form information can be verified will receive notification of their status no later than 30 days following receipt of the application. A letter will be sent to applicants who are not reachable by telephone and such applications will be held for at least 35 days before final action is taken.
46. The HMO/CMP provides the applicant with a signed and dated copy of the application form. **HMO Manual § 2001.6**	DoD will meet this requirement. Each applicant will be provided a signed and dated copy of the application form.

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HCFA Requirements:	Determination
47. The HMO/CMP transmit the applicant's enrollment information to HCFA within 30 days from the date of application or from the date a vacancy occurs if the latter is due to capacity restrictions (or, within an additional period of time approved by and HCFA) **42 CFR 417.430(b) (6); HMO Manual § 2001.7**	DoD will meet this requirement. HCFA will be provided applicant's enrollment information within 30 days from the date of application or from the date a vacancy occurs.
48. If the application is denied, then the HMO/CMP, within 30 days of application, provides the applicant with a written explanation of the reason for the denial. **42 CFR 417.430(b) (5); HMO Manual § 2001.6**	DoD will provide a written explanation of the reason for the denial, e.g. ESRD, hospice care election in a Medicare-certified hospice, etc. The application will contain a section that explains denial of application. Applicants will certify that they understand this section by initialing the section
49. When the HMO/CMP receives enrollment confirmation from HCFA, it promptly (within 14-30 days) notifies enrollees in writing of the effective date of enrollment, and sends HCFA-approved information on the rules, including benefits and enrollee rights and responsibilities. **42 CFR 417.430(b) (7) and 42 CFR 417.436(b);HMO Manual § 2001.5B**	DoD will meet this requirement. Upon notification from HCFA, DoD will notify enrollees in writing of the effective date of enrollment, and send HCFA-approved information on the rules, including benefits and enrollee rights and responsibilities.
50. When the HMO/CMP is filled to capacity, or closes enrollment following at least a 30-day open enrollment period, it notifies subsequent applicants in writing of the procedures that will be followed when enrollment reopens or vacancies occur. The procedures ensure that vacancies are filled in chronological order. **42 CFR 417.430(b) (8); HMO Manual § 2001.3F**	DoD will meet this requirement. Once enrollment capacity has been reached, prospective enrollees will be notified in writing of the procedures that will be followed when enrollment reopens or vacancies occur. Applicants will be offered the opportunity to be placed on a waiting list.
51. The HMO/CMP adheres to the requirements in requesting retroactive enrollments from the HCFA Regional Office. **HMO Manual § 2002 A and B**	DoD will meet this requirement Retroactive enrollment will be processed only in the event that enrollment was denied because an error or technical problem in the HCFA system resulted in the provision of inaccurate beneficiary information. Such applicants shall be enrolled regardless of capacity limits.

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EMPLOYER GROUP APPLICANTS AND ENROLLEES

HCFA Requirements:	**Determination:**
52. RISK HMO/CMPs ONLY (retroactive enrollment only): The HMO/CMP enrolls Medicare Employer Group Health Plan (EGHP) applicants who are enrollees of an employer group plan and certifies that it provided him/her with an explanation of enrollee rights, including the lock-in requirements. **§ 4204(e) OBRA 1990; HMO Manual § 2002 A**	Enrollment will be for Medicare-eligible MHSS beneficiaries who are 65 and over. DoD will not contract with employer groups for the purposes of this demonstration.
53. The HMO/CMP does not exceed the limitation (up to 90 days) which allows HCFA to retroactively adjust Medicare payments to the HMO/CMP to cover the period of time the applicant enrolls through the EGHP and becomes eligible to receive services under the risk contract, and the time the application is received by the HMO/CMP and transmitted to HCFA. **§ 4204(e) OBRA 1990; HMO Manual § 2002 A**	Not applicable.
54. The HMO/CMP accepts as a Medicare enrollee any individual who applies and is enrolled in the HMO/CMP during the month immediately before the month of entitlement to Medicare parts A and B, or Part B only (Conversion). **42 CFR 417.432; HMO Manual § 2003.5**	The MTF will enroll into the TRICARE Medicare Prime program any TRICARE Prime enrollee who becomes eligible for Medicare and who was enrolled in the HMO/CMP with a PCM at the MTF during the month immediately before the month of entitlement to Medicare parts A and B. Those TRICARE Prime enrollees with civilian PCMs in the service area will be given an opportunity to apply for enrollment and will be eligible for the waiting list as appropriate.

HCFA Requirements:	Determination:
55. For "working aged" HMO/CMP enrollees who are employed by groups which are subject to Medicare Secondary Payer regulations, the HMO/CMP only offers premium waiver (or premium reduction) if the enrollee maintains coverage through both the TEFRA risk product and the group product. **§ 4204(g) (1) (C) OBRA 1990**	DoD will meet these requirements.
56. EGHP applicants who live outside of the Medicare service area are given the opportunity to convert into the Medicare HMO/CMP, but are informed in writing of the requirement that they utilize providers within the approved Medicare service area. Such enrollees are not disenrolled due to a "move" outside the service area, unless their residence changes following enrollment. **42 CFR 417.432(c)**	Not applicable.

MEMBERSHIP

HCFA Requirements:	Determination:
57. The HMO/CMP notifies Medicare enrollees of the changes in its rules, at least 30 days before the effective date of the change. **42 CFR 417.436(c)**	DoD will comply with this requirement

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PREMIUMS AND OTHER AMOUNTS DUE

HCFA Requirements:	**Determination:**
58. The HMO/CMP does not make changes during the contract year which result in an increase in premiums or a decrease in benefits. If there is a mid-year regulatory change in Medicare programs benefits, the HMO/CMP notifies its enrollees of the added benefits. . **§ 1876(c) (2) (B) of the Social Security Act.**	DoD will comply with this requirement.
59. When the HMO/CMP incorrectly collects premiums and/or other amounts due (as defined in 42 CFR 417.456(a) (1) (2) (3)), it refunds those amounts to Medicare enrollees, or to others who made payments on behalf of such enrollees. **42 CFR 417.456(c) and (d); HMO Manual § 2170.3**	DoD will comply with this requirement. Co-payments will not apply to care provided within the MTF.
60. The HMO/CMP refunds incorrectly collected amounts by lump sum payment and/or by future premium adjustments. **42 CFR 417.456(c) and (d); HMO Manual § 2170.3**	DoD will comply with this requirement

REPORTING AND RECONCILIATION OF RECORDS

61. The HMO/CMP reviews the *HCFA Monthly Transaction Replies/Monthly Activity Report* listings and the *Maintenance Records* upon receipt and appropriately follows up on any change in enrollee's status. **HMO Manual 6004**	DoD will comply with this requirement
62. The HMO/CMP verifies its enrollees' institutional status at the beginning of each month, correctly defines such status, accurately identifies those enrollees that resided in an institution for the full month, and submits such data to HCFA. **HMO Manual 6008A 1**	DoD will comply with this requirement.

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RISK-BASED CONTRACTORS ONLY - WORKING AGED

HCFA Requirement:	Determination
63. The HMO/CMP has an effective system in place to track, control, and report enrollees' working aged status. **HCFA Program Updates, October 11 and October 20, 1994.**	The MCS contractor will administer the "HCFA Working Aged Survey" to all new members of TRICARE Senior Prime at the time of enrollment. For dual eligibles who submit applications by mail, the MCS contractor will follow-up in writing or by phone in the event the survey is not submitted or incomplete. Ongoing identification of working aged will be accomplished through an annual survey which will be given to all TRICARE Medicare Prime members. DoD will report working aged data to HCFA by the last workday of the month through the McCOY system. The MCS contractor will verify HCFA data from the common working file upon receipt.

DISENROLLMENT
GENERAL PROCEDURES (Voluntary and Involuntary Disenrollments)

HCFA Requirements:	Determination:
64. The HMO/CMP promptly disenrolls Medicare enrollees upon receipt of their written request (i.e., Disenrollments are effective no earlier than the first day of the month following the month or no later than three months from the date the HMO/CMP receives the request. Enrollees are not required to submit disenrollment requests within a specified time frame in advance of the desired date. Disenrollment requests accepted by the HMO/CMP are signed and dated by Medicare enrollees. If the enrollee is unable to manage his/her affairs, a court-appointed guardian or representative may sign and date the disenrollment request. **42CFR 417.461**	DoD will comply with this requirement. Enrollees will be disenrolled upon receipt of their written request. Enrollees will be disenrolled within 60 days of receipt of written request.

GENERAL PROCEDURES (Involuntary Disenrollments Only)

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HCFA Requirements:	**Determination**
65. The HMO/CMP does not, orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll except for failure to pay premiums, a move outside the geographic area, fraud or abuse of membership card, failure to convert to the risk contract, loss of Part B, death of the enrollee, or for cause. **42 CFR 417.460(a); HMO Manual § 2004.1**	DoD will comply with this requirement. DoD staff will be informed that Medicare enrollees will not be requested or encouraged to disenroll.
66. The HMO/CMP notifies Medicare enrollees, in writing, of the intent to disenroll them on an involuntary basis and mails such notices to enrollees and allows a reasonable amount of time for the enrollees to respond (at least 29 days following the date of the notice) before the effective disenrollment date and prior to sending notice to HCFA. The notice contains the proposed effective date, a clear explanation of the reason for disenrollment, information on the enrollee's right to a hearing under the HMO/CMP's grievance procedure, and a reminder that the enrollee must receive services through the HMO/CMP until the effective termination date. **42 CFR 417.460 and following; HMO Manual § 2004.9**	DoD will comply with this requirement. DoD will notify enrollees, in writing, of the intent to disenroll on an involuntary basis. Enrollees will be given a reasonable amount of time to respond before the effective disenrollment date and prior to sending notice to HCFA.

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INVOLUNTARY DISENROLLMENT - FAILURE TO PAY PREMIUM

HCFA Requirement:	Determination:
67. The HMO/CMP's disenrolls Medicare enrollees who fail to pay premiums or other imposed charges only after demonstrating it made reasonable efforts to collect amounts due. **42CFR417.460(c)(1)(i)**	DoD will comply with this requirement. DoD will disenroll Medicare enrollees who fail to pay premiums or other charges after a reasonable effort to collect has been made.

INVOLUNTARY DISENROLLMENT -ENROLLEE MOVES OUT OF HMO/CMP's GEOGRAPHIC AREA

HCFA Requirement:	Determination:
68. Except as specified in 42 CFR 417.460(a)(2)(iv), the HMO/CMP disenrolls Medicare enrollees who move outside of the approved service area for more than 90 consecutive days. **42CFR417.460(b)(2)**	DoD will comply with this requirement. DoD will disenroll a Medicare enrollee who has moved outside of the approved service area for more than 90 consecutive days.
69. The HMO/CMP makes reasonable efforts to establish that Medicare enrollees have permanently moved from the approved service area. Such efforts are documented in writing or evidence exists in some other form acceptable to HCFA. **42CFR417.460(f); HMO Manual 2004.3**	DoD will comply with this requirement. If DoD believes that an enrollee has permanently moved from the approved service area, it will make reasonable effort verify the moved, e.g., telephone calls to the enrollee, letters to the enrollee, asking the enrollee on the next visit.
70. When the HMO/CMP retains enrollees who leave the service area for more than 90 consecutive days, it agrees in writing with the enrollee on restrictions for obtaining health care; however, restrictions are not imposed on the scope of Medicare-covered services as defined in 42 CFR 417.400. **42CFR417.460(f)**	DoD does not propose to retain enrollees who leave the service area for more than 90 consecutive days.

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71. The option to retain Medicare enrollees who are on extended absence from the service area (more than 90 consecutive days) is made available to all enrollees, unless the HMO/CMP is affiliated with other organizations, in which case it limits the option to enrollees who more to a geographic area served by the related organization which has both a contract under section 1876 of the Act and meets the definitions of "affiliated organization." **42CFR417.460(f)(2); Federal Register, Vol.56.No. 178**	DoD does not propose to retain enrollees who leave the service area for more than 90 consecutive days.
72. The HMO/CMP disenrolls enrollees who leave the HMO/CMP's service area for an extended absence and fail to return within one year of the date he or she left the geographic area. **42CFR417.460(f)(2); Federal Register, Vol.56.No. 178**	DoD will comply with this requirement. DoD will disenroll enrollees who leave the service area for an extended absence and fail to return within one year of the date he or she left the geographic area.

INVOLUNTARY DISENROLLMENT -FRAUD OR ABUSE OF MEMBERSHIP CARD.

HCFA Requirement:	**Determination:**
73. Medicare enrollees who are disenrolled for fraud or abuse are only disenrolled if they knowingly provide fraudulent information which materially affects the organization or affects the applicant's eligibility to enroll, or because an enrollee intentionally permits others to use the membership card to receive HMO/CMP services. **42CFR417.460(d)**	DoD will comply with this requirement. DoD will certify all disenrollments for fraud or abuse. These causes will be reviewed to determined if the enrollee knowingly provided fraudulent information or intentionally permitted others to use their membership card to receive services.
74. The HMO/CMP advises HCFA of such disenrollments only after reasonable advance notice is given to enrollees. **42CFR417.460(d)(2)**	DoD will comply with this requirement. DoD will notify HCFA of disenrollments after advance notice is given to enrollees.

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HCFA Requirement:	Determination
75. The HMO/CMP maintains documents related to the decision to disenroll and reports these disenrollments to the Office of Inspector General. **42CFR417.460(d)(3)**	DoD will comply with this requirement. DoD will maintain documents related to the decision to disenroll. DoD will report disenrollment for cause to the Office of Inspector General.

INVOLUNTARY DISENROLLMENT -LOSS OF MEDICARE Part A and/or Part B ENTITLEMENT

HCFA Requirement:	Determination:
76. The HMO/CMP disenrolls Medicare enrollees who lose Part B entitlement effective with the month following the last month of such entitlement. **42CFR417.460(h)(2)**	DoD will comply with this requirement. DoD will disenroll enrollees who lose Part B entitlement. The disenrollment will be effective with the month following the last month of entitlement.
77. Enrollees who lose entitlement to Part A, but remain entitled to Part B of Medicare, automatically continue in the HMO/CMP as Part B enrollees. **42CFR417.460(h)(1)**	Compliance with this requirement is not possible because the demonstration project requires participants to be eligible for both Part A and Part B benefits, and DoD will disenroll enrollees who lose entitlement to Part A. Under the authority of section 1896(d)(1) of the Social Security Act, a waiver of this requirement is granted.

INVOLUNTARY DISENROLLMENT -FOR CAUSE

HCFA Requirement:	Determination:
78. The HMO/CMP disenrolls Medicare enrollees for cause only when their behavior is disruptive, unruly, abusive, or uncooperative to the extent that continuing seriously impairs the HMO/CMP's ability to furnish services to either the enrollee or other enrollees. **42CFR417.460(e)(1)**	DoD will comply with this requirement. DoD will disenroll Medicare enrollees for cause when their behavior is disruptive, unruly, abusive, or uncooperative and reasonable efforts have been unsuccessful in resolving the issue.

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HCFA Requirement:	**Determination:**
79. The HMO/CMP disenrolls Medicare enrollees for cause only after serious efforts to resolve the problem, including use of internal grievance procedures, consideration of extenuating circumstances, and HCFA's advance approval of the proposed disenrollment. **42CFR417.460(e)(2)**	DoD will comply with this requirement. MTFs will establish, through their internal grievance process, procedures to ensure that appropriate steps have been taken to resolve the problem prior to disenrolling a Medicare enrollee for cause.
80. The HMO/CMP disenrolls enrollees effective the first day of the calendar month after the month in which notice is given to them of the intended action. **42CFR417.460(e)(6)**	DoD will comply with this requirement. DoD will disenroll enrollees effective the first day of the calendar month after the month in which notice is given.

VOLUNTARY DISENROLLMENT

HCFA Requirement:	**Determination:**
81. The HMO/CMP promptly sends a letter to the enrollee acknowledging receipt of the disenrollment request, and includes a copy of the enrollee's written request to disenroll. The letter contains the proposed effective date, and explains that the enrollee must continue to receive health care from the HMO/CMP providers until that date. **42CFR417.460(b)(2)**	DoD will comply with this requirement. DoD will acknowledge receipt of enrollee's disenrollment request. The letter to the enrollee will include a copy of the enrollee's request, a proposed effective date, and an explanation that the enrollee must continue to receive health care from DoD until that date.

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CLAIMS PROCESSING

HCFA Requirement:	Determination:
82. The HMO/CMP assumes financial responsibility and provides reasonable reimbursement for emergency services (in and out of area) and urgently needed services (out of area only) that its Medicare enrollees obtain outside the HMO/CMP, even without prior authorization. **42CFR417.414(c)**	DoD will comply with this requirement.
83. The HMO/CMP (including its contracting providers) pays 95 percent of "clean" claims from unaffiliated providers within 30 days of receipt. When clean claims are paid in over 30 days, interest is computed and paid. **Appropriations Bill, October 1992, P.L. 102-394; Sections 1876(g)(6)(A), 1842(c)(2) and 1816(c)(2) of the Social Security Act, and Section 9311 of OBRA 1986.**	DoD will comply with this requirement.
84. The HMO/CMP (including its contracting providers) makes an initial determination within 60 days from receipt of claims (from both affiliated and unaffiliated providers). If the HMO/CMP makes a determination that is wholly or only partially adverse to the enrollee, it notifies the enrollee of its determination (denial) within 60 days from receipt of the claim. To make initial determinations timely, 95 percent of claims are processed within 60 days from the date of receipt. **42CFR417.608(a)**	DoD will comply with this requirement.
85. The HMO/CMP notifies the enrollee of the right to appeal if it has failed to make a determination (adverse) within 60 days of receipt of the claim (i.e., failure to provide notice is deemed an adverse initial determination subject to appeal. **42CFR417.608(c)**	DoD will comply with this requirement.

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MEDICARE APPEALS **

HCFA Requirement:	**Determination:**
86. The HMO/CMP establishes, maintains, and follows the appeals procedures and procedures for expedited reviews, and informs all enrollees in writing of the appeals and expedited review procedures for all organization determinations. Information on these processes is clearly described in the HMO/CMP's evidence of coverage (EOC). **42CFR417.600; 417.604; 417.609; 417.617**	DoD will meet this requirement.
87. The HMO/CMP properly defines and identifies complaints that are organization determinations: (1) reimbursement for emergency or urgently needed services; (2) services furnished by nonaffiliated providers or suppliers that the enrollee believes is covered by the HMO/CMP contract and should have been furnished, arranged for, or reimbursed by the HMO/CMP; (3) services which the HMO/CMP refuses to provide that the enrollee believes should be furnished through the HMO/CMP and the enrollee has not received outside the HMO/CMP; and (4) discontinuation or reduction of a service. **42CFR417.606**	DoD will meet this requirement

88. The HMO/CMP makes an organization determination (the HMO/CMP's decision to provide, authorize, deny, or pay for a service, or the discontinuation of a service) within 60 days of the enrollee's request for the service. Failure to provide a notice constitutes an adverse organization determination which the enrollee may appeal (i.e., the situation is deemed adverse). **42CFR417.608**	DoD will meet this requirement.
89. The HMO/CMP's decision to deny payment for claims, refusal to provide or authorize a service, or to discontinue a service is an adverse organization determination. The written notice of an adverse organization	DoD will meet this requirement.

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determination: states the specific reasons for the denial; informs the enrollee of the right to a reconsideration, including the right to an expedited reconsideration; includes information regarding availability of legal assistance; provides parties to the reconsideration reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing; and includes information explaining that physicians and other health professionals may act on behalf of an enrollee in time-sensitive situations. **HMO Manual 2304.4 42CFR417.608 and 417.618**	
90. The HMO/CMP develops procedures to assure that contracting providers are fully informed of appeals procedures and their responsibility to provide written notice of adverse organization determinations. The HMO/CMP monitors these procedures. **42CFR417.606**	DoD will meet this requirement
91. The HMO/CMP accepts requests for reconsiderations and expedited reconsiderations filed within 60 days of the organization determination. **42CFR417.616**	DoD will meet this requirement
92. The HMO/CMP assures that someone not involved in making organization determination makes the reconsideration (second level of review of an adverse organization determination) decision. **42CFR417.622**	DoD will meet this requirement
93. The HMO/CMP either makes a fully favorable decision and issues a decision within 60 days to the enrollee, or, if the HMO/CMP is unable to make a fully favorable decision, the HMO/CMP forwards the case to HCFA within 60- days from the date of receipt of the reconsideration request and concurrently notifies the beneficiary of the action. **42CFR417.620(b); 417.620(c); and 417.620(f)**	DoD will meet this requirement
94. If HCFA's reconsideration determination is to hold the HMO/CMP liable, then the	DoD will meet this requirement

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HMO/CMP provides or pays for the service within 60 days from the date of HCFA's determination. **Article IV, Medicare Contract**	
95. The HMO/CMP's written grievance procedures include: • a thorough explanation of the steps to follow in completing the procedure; and • time limits for each step of the procedure. **42CFR417.600 and 417.124(g)**	DoD will meet this requirement.

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HCFA Requirement:	Determination:
96. The HMO/CMP properly identifies issues subject to the grievance process. Anything not subject to appeals is considered a grievance; examples: quality of service provided, long waiting times for appointments or at the physician's office, services covered under an optional supplemental plan, issues relating to premiums, and involuntary disenrollment. **42CFR471.606(c)**	DoD will meet this requirement
97. The HMO/CMP allows physicians and other health professionals to act on behalf of an enrollee in time sensitive situations when an organization determination or reconsideration is being requested. **42CFR417.604(b)(4); 417.609(c)(4); 417.617(c)(4)**	DoD will meet this requirement
98. The HMO/CMP maintains and follows expedited organization decision and reconsideration procedures which include: (1) the receipt of oral requests, followed by written documentation, within two working days, of the oral request; (2) prompt decision-making, i.e., within 72 hours, regarding whether the request will be expedited or handled within the standard 60-day time frame, including timely notification of the enrollee if the request is not expedited.; (3) notification of the enrollee or the physician/health professional, as appropriate, as expeditiously as the enrollee's health condition requires, but within 72 hours of the request of the decision regarding expediting the case, and (4) an extension of up to ten working days for the decision, if requested by the enrollee or if the HMO/CMP finds that additional information is necessary and the delay is in the interest of the enrollee. **42CFR417.609; 417.617**	DoD will meet this requirement
99. The HMO/CMP forwards cases to HCFA within 24 hours of making a decision, or within 72 hours (or the extension period) when no favorable decision is made. **42CFR417.620**	DoD will meet this requirement

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Attachment C—Reimbursement

Overview

This attachment, and figures 1 through 19, describe the specific process for Medicare Program reimbursement to the Department of Defense (DoD) and for the end-of-year reconciliation.

Medicare Interim Payments to DoD

Under the demonstration, DoD may receive interim payments for the enrollment and treatment of its dual-eligible beneficiaries. During the execution of the demonstration project during any demonstration year, the department may receive a monthly per-member per-month capitated amount for TRICARE Senior Prime enrollees when the site's enrollment is above a specified threshold. These payments are interim, or provisional, payments. At the end of each demonstration year, a reconciliation will be conducted to determine whether DoD is entitled to keep any of its interim payments, and to determine if the amount of reimbursement was appropriate. This appendix describes the threshold mechanism that triggers the interim monthly payments. Then it describes the reconciliation process.

Thresholds for Reimbursement and Reconciliation

For each demonstration year and each demonstration site, DoD and HCFA will establish a threshold that will determine whether HCFA will reimburse DoD for enrollment at the site and determine the size of the reimbursement. The triggering threshold derives from each individual site's historical level of expenses for its dual eligible beneficiaries, termed the site's ''level of effort''. Calculation of the site's baseline level of effort is described in Appendix D.

The threshold for triggering interim payments from Medicare will be calculated from a portion of each site's level of effort. The portion will be 30 percent of the site's level of effort for the first demonstration year, 40 percent in the second demonstration year, and 50 percent in the third. The 30 percent portion for the first demonstration year will be scaled, or prorated, to the number of months of care delivery at each site. For example, if a site's level of effort was $90 million and delivered care for 5 months of the first demonstration year, the portion used to calculate a reimbursement threshold would be $11.25 million (5/12ths of 30 percent of $90 million).

The monthly threshold that triggers payments will be calculated by dividing the total dollar portion determined in the previous paragraph by the months of care delivery for the site. Continuing the example above, the monthly threshold will be $2.25 million ($11.25 million divided by 5 months).

HCFA will calculate the amount that it would pay for all of DoD's enrollees under the demonstration program at a modified per capita Medicare+Choice reimbursement rate (described in the next section), and compare its calculated amount to the site's monthly threshold. If the calculated amount exceeds the monthly threshold, then HCFA will reimburse DoD for the difference as an interim payment. If the calculated amount is below the monthly threshold, HCFA will not make a payment to DoD for that month. Failure to enroll up to the threshold in a month will also result in an adjustment to interim payments from other months (described under Annual Reconciliation below). Payments for all demonstration sites combined are subject to a global cap for each demonstration year. The caps are $50 million for the first demonstration year, $60 million the second year, and $65 million the third. No more than 50 percent of the cap in each year shall be available for Medicare Partners.

Per Capita Reimbursement Rate

To calculate how much it would pay for TRICARE Senior Prime enrollees in the reimbursement mechanism (described in the previous section), HCFA will use the following rate. The reimbursement rate by Medicare to DoD is 95 percent of the applicable Medicare+Choice rate as determined under the Balanced Budget Act of 1997 (P.L. 105–33) . In accordance with the authorizing legislation, the Medicare+Choice rate for each county will be adjusted to remove payments for graduate medical education (GME), indirect medical education (IME), and disproportionate share hospital (DSH). In accordance with the agreement by both Secretaries, 67 percent of capital will be removed.

Annual Reconciliation

At the end of each demonstration year, DHHS and DoD will conduct a formal reconciliation and evaluation to determine whether (1) all site's are entitled to retain the reimbursements they received from Medicare and (2) whether the amount of reimbursement were appropriate. The reconciliation consists of four steps:

1. Accumulate DoD's Expenses. The first step will be to determine the total amount of DoD expenditures across all six demonstration site for all dual-eligible beneficiaries residing in the service area. Two categories of expense will be accumulated: (1) expenses for care provided on a space-available basis to non-enrolled dual eligible beneficiaries (termed ''space-available level of effort''), and (2) expenses for care provided to enrollees.

Expenses for providing outpatient pharmacy services will not be included in any of the categories; nor will expenses incurred providing services under a Medicare Partners contract for services covered by the contract. Expenses incurred providing services not covered by a Medicare Partners agreement will be counted as space-available care.

Expenses for space-available care are capped at a maximum of 70 percent of the combined level of effort across all six sites during the first demonstration year, 60 percent of the combined level of effort during the second, and 50 percent during the third. Because sites will be starting care delivery at varying time during the first demonstration year, the demonstration-wide cap on space-available expenses will be prorated during the first demonstration year as follows. Each individual site's level of effort will be prorated according to the number of months of care delivery during that first demonstration year. Then, the prorated level's of effort will be added across all six sites. Finally, 70 percent of the six site total will be used for the first year space-available cap.

2. Determine Eligibility for Reimbursement. The second step will be to determine whether the demonstration sites are eligible to retain any reimbursements from Medicare. There are two tests; both must be passed. The first compares total expenditures for all six sites, both for enrolled and for space available care, to DoD's combined level of effort for all sites. For any site to be eligible to retain reimbursements from HCFA, DoD must reach its combined level of effort.

The second test compares DoD's expenditures for enrolled care across all demonstration sites against a minimum threshold that varies by demonstration year. The threshold is 30 percent of the combined six-site level of effort during the first demonstration year, 40 percent during the second, and 50 percent during the third. Again, the first year threshold on expenses for enrolled care will be prorated by the number of months of care delivery during that year in the manner similar to the way the threshold for space-available care is prorated (described in 1. above).

3. Determine Amount of Reimbursement. If DoD has met its level of effort for all demonstration sites, reimbursements from HCFA are subject to two adjustments. First, gross monthly payments from HCFA to a site will be summed over all months of a demonstration year (months of care delivery for the first demonstration year). The difference between this sum and the level of effort target will be the annual reimbursement that DoD is entitled to keep at each site. If the difference is negative, DoD will return all payments received to HCFA. This adjustment is performed at each site.

Second, total reimbursements from HCFA may be adjusted upwards or downwards during reconciliation if there is compelling evidence of adverse or favorable risk selection in DoD's enrollment, when compared with the HCFA population upon which the Medicare+Choice rates are based. The determination will be made analytically during as part of the reconciliation process and will be based upon submitted claims for covered services.

Third, DoD is only entitled to retain reimbursement above the aggregate level of effort. The level of effort will be prorated during the first demonstration year on the basis of months of care delivery at the various sites.

4. Provide Access to Data. The final step will be to provide HCFA auditors and the DHHS IG with access to DoD's records and data for demonstration sites. HCFA and DoD will develop a mutually acceptable process for settling any disputes that arise over the data.

Maximum Ceiling on Total Annual Medicare Reimbursement

For the demonstration project, the maximum total Medicare reimbursement to DoD for all six demonstration sites in any demonstration year shall not exceed $50

million in calendar year 1998, $60 million in calendar 1999, and $65 million in calendar year 2000. The cap for the first demonstration year will be prorated as described below. All reimbursements received by DoD for dual-eligible enrollees from Medicare or from Medicare Partners will count towards the annual ceiling. Should Medicare reimbursement to DoD meet the statutory cap in any of the project's three years, DoD will remain obligated to continue to provide the full range of services under the TRICARE Senior Prime benefit to all project enrollees. DoD will be financially liable for all care provided under TRICARE Senior Prime once the annual reimbursement cap is reached. No more than 50 percent of the cap in each year shall be available for Medicare Partners.

For 1998, the $50 million ceiling shall be prorated based on the estimated enrollment at each site and the number of months that each site is operational during 1998. The ceiling for 1998 will be determined when the last site to begin in 1998 becomes operational.

At the end of each month, DoD will report to HCFA all revenue that it has received during that month from Medicare+Choice plans. HCFA will track payments for TRICARE Senior Prime enrollees. If the annual cap for that year was exceeded in a prior month, DoD will remit all such revenue for each succeeding month to HCFA.

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Establish Thresholds for Payment

- Split the level of effort at each site to establish a threshold for triggering reimbursement.
- Method for splitting:
  - » Split on a percentage basis.
  - » 30 percent of a site's level of effort for the first demonstration year, 40 percent the second year, and 50 percent the third.
- First year's threshold at each site is prorated by that sites number of months of care delivery during the first demonstration year.

Figure 1

Establish Reimbursement Threshold

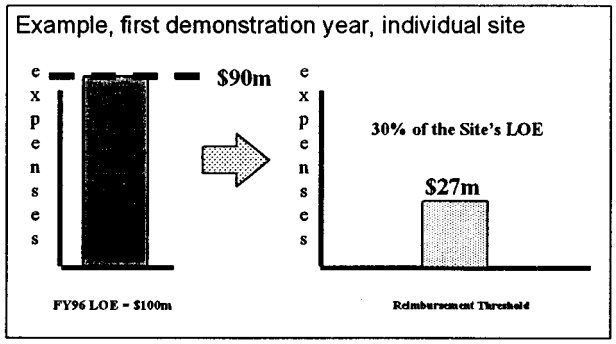

Figure 2

Attachment C

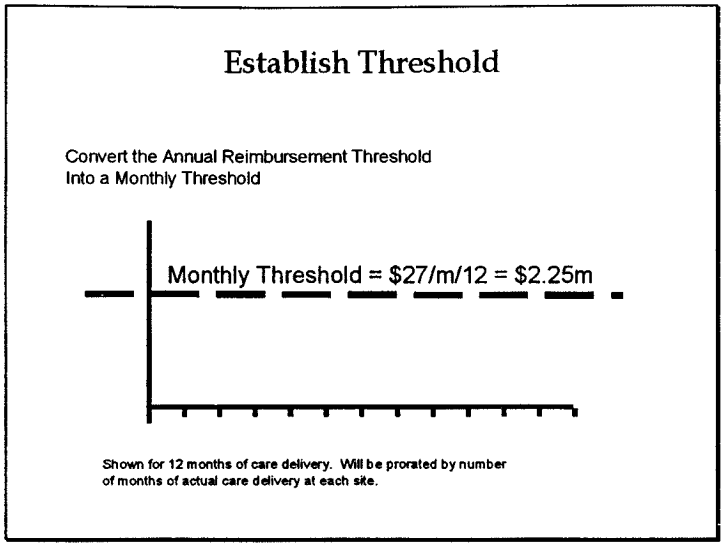

Figure 3

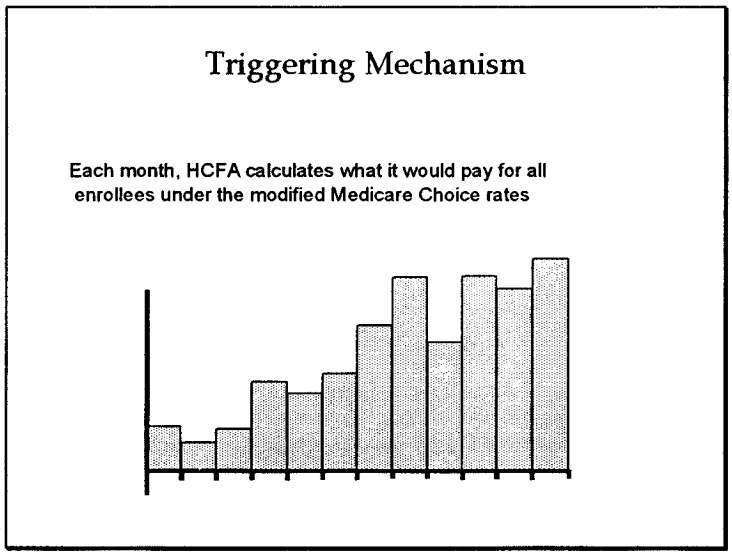

Figure 4

Attachment C

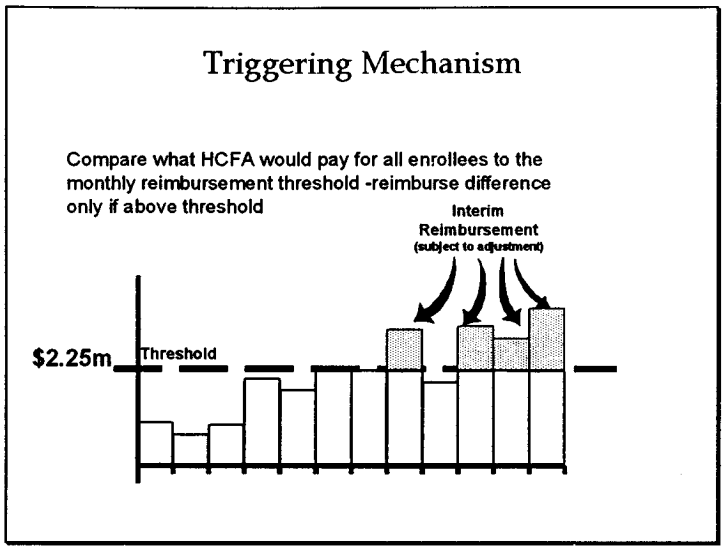

Figure 5

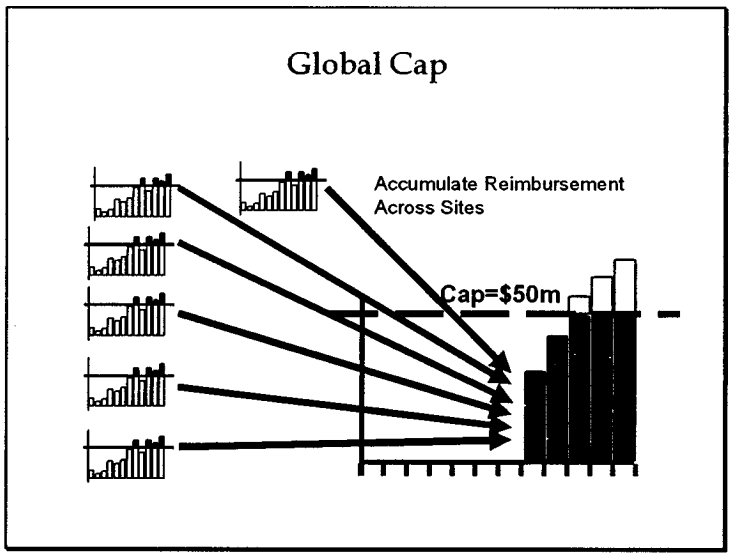

Figure 6

Attachment C

Reconciliation for Each Site

- Based upon actual expenses during execution year.
- Two Issues addressed during reconciliation:
  - » Did DoD reach the combined LOE? Determines entitlement for reimbursement.
  - » Was the amount of reimbursement appropriate?
- Steps:
  - » 1. Accumulate expenses in two categories across all sites: expenses for Space-Available Care and expenses for Enrolled Care.
  - » 2. Test whether the combined six-site LOE was met.
  - » 3. Determine whether reimbursement amount was correct.

Figure 7

Tests for Meeting LOE

Two tests:

- Did the combined expenses for space-available care (capped) and expenses for enrolled care meet or exceed total LOE.
- Did expenses for enrolled care at all six sites exceed the minimum threshold for the demonstration (30%, 40%, or 50% of the combined six-site LOE in years 1, 2, and 3, with year 1 prorated).

Figure 8

Attachment C

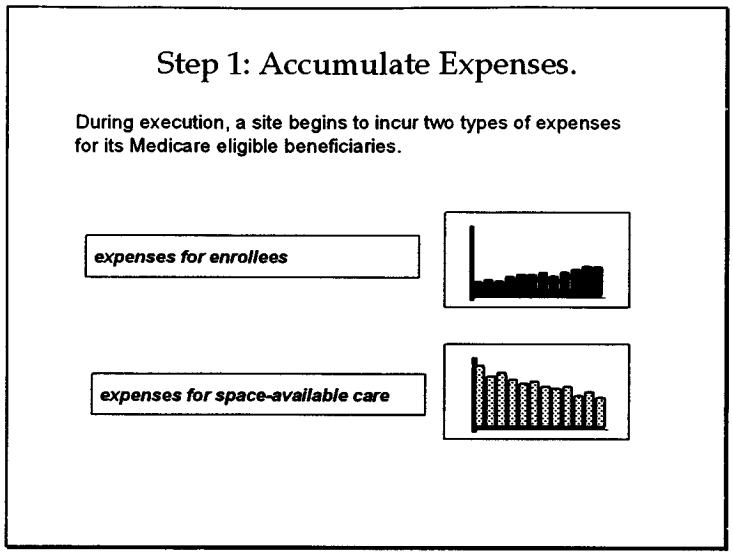

Figure 9

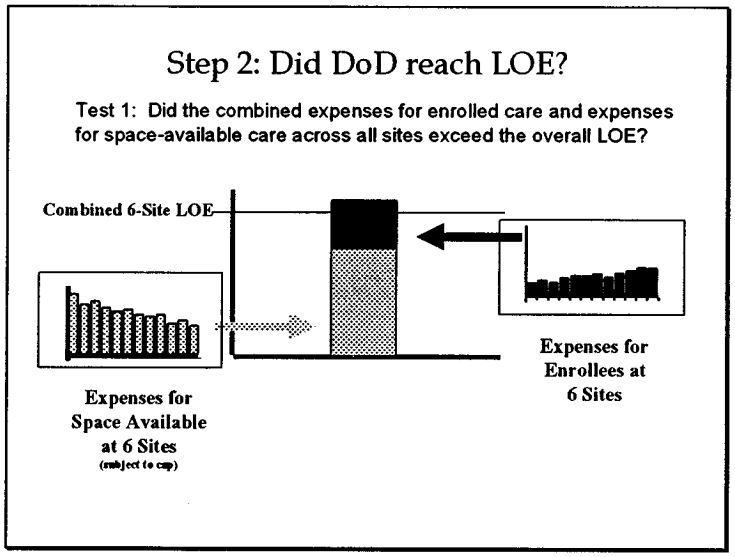

Figure 10

Attachment C

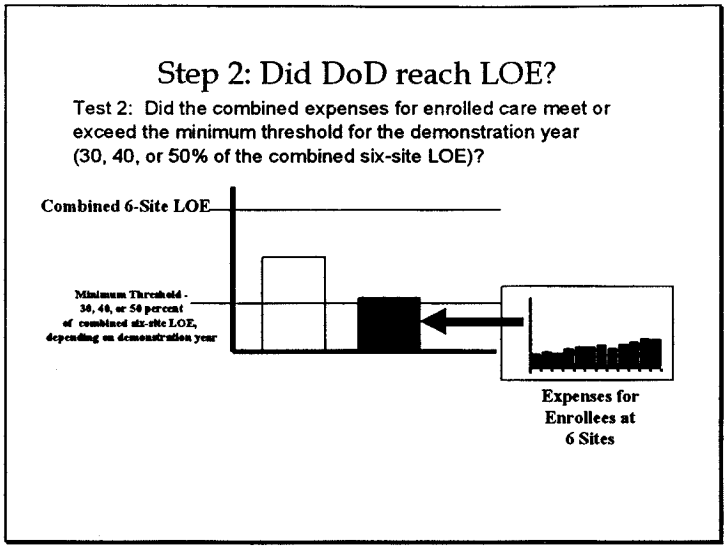

Figure 11

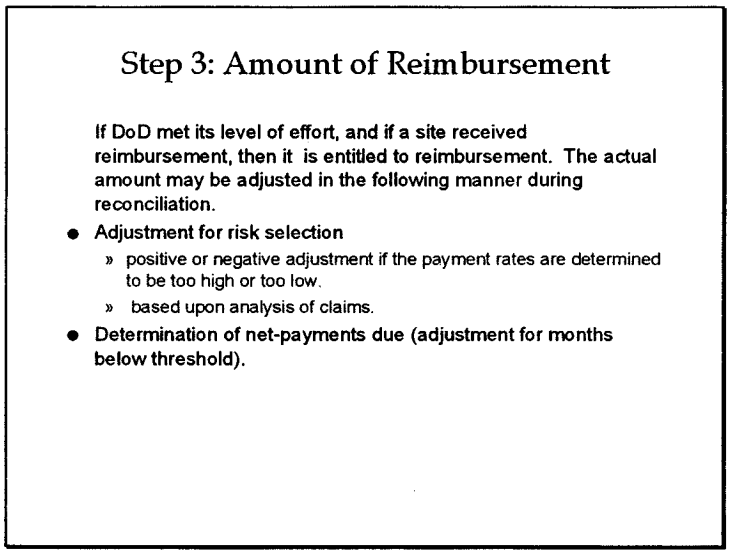

Figure 12

Attachment C

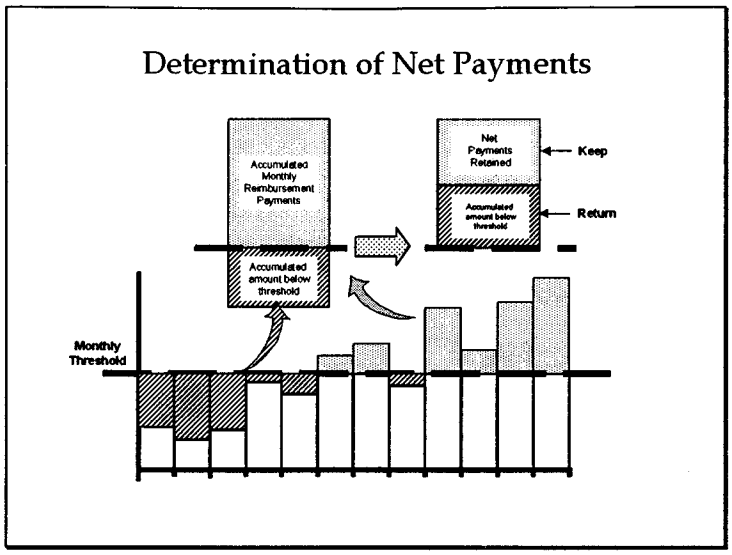

Figure 13

Medicare Partners

- Expenses for services covered by a Medicare Partners contract are not counted toward enrolled care or space-available care in meeting LOE.
- Expenses incurred by Medicare HMO enrollees for service not covered by a Medicare Partners contract are space-available care for meeting LOE.
- If DoD does not meet its LOE, all reimbursements from all Medicare Partners contracts will be returned to HCFA.

Figure 14

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Attachment D—Level of Effort

Introduction

Purpose

This attachment describes the methodology that the Department of Defense (DoD) will use to compute the FY96 ''level of effort'' (LOE) for each Medicare Demonstration site.

General Principles for Establishing Medicare Level-of-Effort

DoD will compute the FY96 level-of-effort (historical expenditures for its Medicare eligible beneficiaries) separately for the service area of each Medicare Demonstration site. Service areas will be defined by lists of specific zip-codes for each site. Expenses will be accumulated from a population perspective; they will be the sum of all applicable DHP expenses for all dual eligible beneficiaries living in the zip-codes defining the site, regardless of where in the Military Health System those expenses were incurred.[1]

The LOE will include most direct expenses for inpatient and outpatient care provided by military Medical Treatment Facilities (MTFs), with some additional burdening (explained in detail below) . It will also include the government's costs of care for Medicare eligibles referred to providers in networks operated by the Department's Managed Care Support Contractors. The FY96 LOE excludes any DoD expenses comparable to those removed from the Medicare+Choice rates as a result of the Balanced Budget Act of 1997 (e.g., expenses for Graduate Medical Education), or any types of care specifically excluded by agreement between DoD and HCFA (outpatient pharmacy costs). The FY96 LOE will also exclude DoD's monthly payments for dual-eligible enrollees of Uniform Services Treatment Facilities (USTFs) residing in the service area, unless they participate.

It is the agreement of the administering Secretaries that FY96 will be the baseline.

Detailed Methodology

This section presents the separate methodologies used to estimate inpatient and ambulatory expenses.

Terminology

Medicare Demonstration Sites. In accordance with current legislation, six sites will be picked for the Medicare Demonstration. A service area for each site will be defined geographically by a specific list of zip-codes.

IDA Add-on. In an analysis performed for the ''733 Study,'' the Institute for Defense Analysis (IDA) determined that certain expenses should be added to the clinical expenses reported in the Medical Expense and Performance Reporting System (MEPRS). Based upon their analyses, they estimated the amounts that should be added to inpatient and outpatient clinical expenses as a percentage add-on to the expenses routinely reported in the clinical accounts. Their recommended adjustments are presented in Table 1.

Patient-Level Cost Allocation. The methodology that DoD is evolving to estimate expenses at the level of the individual patient encounter. That methodology is described in a separate document to be provided by DoD.

Inpatient Care

Data Sources

Direct Care

Clinical Data: Standard Inpatient Data Record (SIDR) for each hospital discharge. Maintained in the Corporate Executive Information System (CEIS).

Expenses: Estimated from the Medical Expense and Performance Reporting System—Central (MEPRS), part of the Defense Medical Information System or from the MEPRS Executive Query System (MEQS), depending on military department.

MCSC Provider Network

Expenses: Government paid expense on Health Care Summary Records (HCSRs) provided by the TRICARE Support Office (TSO) to the CEIS.

Methodology

Estimates of total inpatient expenses in each service area are determined by the following process:

1. Estimate inpatient expenses for care in Military Treatment Facilities (MTFs) for all Medicare eligibles in the service area.

a. From the CEIS, isolate the electronic summary discharge records for all non-active duty DoD beneficiaries age 65 and older living in the service area.

b. For each record isolated in step (1), estimate the cost of each discharge.

(1) Estimate the cost for each individual discharge using the Patient Level Costing Allocation (PLCA) methodology, as described in a separate document to be provided by DoD.

(2) Apply the IDA add-ons appropriate to the treating facility.

(a) Burden the cost of each record using IDA's percentages for DMSCC, Mgmt HQ, and Reference Labs, using the percentage developed for the Military Department of the hospital in which the care occurred (see Table 1). By agreement of the two administering Secretaries, burden the cost on each record with ⅓ of the IDA adjustment for Construction (see Table 1).

(b) Burden each record for Continuing Health Education (MEPRS Account FAL) and Patient Transportation/Movement (FEA/FEB/FEC) by allocating the actual expenditures in these accounts for treating facilities in the demonstration service area, and by the IDA percentage add-on (Table 1) for treating facilities outside the demonstration area. Since these accounts support all patient categories, as well as both inpatient and outpatient services, only a portion of their expenses will be allocated to the inpatient treatment of Medicare beneficiaries. The amount of each account allocated to Medicare inpatient expenses will be in the same proportion as MEPRS A Expenses (Inpatient Clinical Expenses) for the Medicare population are to the total of all MEPRS A and MEPRS B (Outpatient Clinical Expenses) in FY96. The amount allocated to Medicare inpatient expenses will be uniformly distributed across all Medicare inpatient records.

c. For records from teaching facilities, deflate the amount using HCFA's adjustment for Indirect Medical Education (IME) based on that facility's count of beds and of interns and residents.

d. Sum the estimated costs for the service area.

2. Estimate inpatient expenses for care provided by the MCSC provider networks.

a. Isolate all Health Care Summary Records for all non-active duty DoD beneficiaries, age 65 and older, living in the service area.

b. Total the government paid portion for all claims. [DHA1]

Outpatient Care

Data Sources

Direct Care

Clinical Data: Monthly outpatient visits by patient age and third-level MEPRS from CHCS, as well as outpatient visits reported by third-level in MEPRS-Central or MEQS.

Expenses: Dollars by third-level MEPRS from MEPRS-Central or MEQS.

MCSC Provider Network

Expenses: Government paid expense on Health Care Summary Records (HCSRs) provided by the TRICARE Support Office (TSO) to the CEIS.

Methodology

The following steps will be used to estimate outpatient expenses in each region:

1. Estimate the outpatient expenses for Medicare eligibles at all MTFs in the service area using the following steps.

a. Reconcile CHCS and MEPRS visit data.

(1) Annualize the CHCS data.

(2) Scale CHCS visit accounts to MEPRS or MEQs, if necessary.

b. From the rescaled CHCS visit data, determine the proportion of visits in each workcenter (third-level MEPRS) that are for non-active duty beneficiaries age 65 and older.

c. Apply the proportion of non-active duty beneficiaries age 65 and older to the MEPRS workcenter costs, excluding outpatient pharmacy expenses from the stepdown to ambulatory workcenters.

d. Sum the costs for the beneficiaries under consideration across all MEPRS workcenters to get total outpatient visit expenses at the facility level.

e. Apply the IDA add-ons for outpatient care.

(1) Inflate each record using IDA's percentages for DMSCC, Mgmt HQ, Reference Labs, and Clinical Investigation, using the percentage developed for the Military Department of the hospital in which the care occurred. By agreement of the two administering Secretaries, burden the cost on each record with ⅓ of the IDA adjustment for Construction (see Table 1).

(2) Burden the total expenses from d. by expenses in Continuing Health Education (MEPRS Account FAL) by allocating actual expenditures in the FAL account of the

[1] By contrast, a ''facility view'' of a demonstration area would accumulate the selected DHP expenses for beneficiaries treated by facilities operating within the service area, regardless of where such beneficiaries reside.

treating facility. The amount of each account allocated to Medicare outpatient expenses in the same proportion as MEPRS B Expenses (Outpatient Clinical Expenses) for the Medicare population are to the total of all MEPRS A (Inpatient Clinical Expenses) and MEPRS B in FY96. The amount allocated to Medicare outpatient expenses will be uniformly distributed across all Medicare outpatient records.

f. Sum the estimates for all MTFs within the service area.

2. Estimate ambulatory expenses for care provided by the MCSC provider networks.

a. Isolate all Health Care Summary Records for all non-active duty DoD beneficiaries, age 65 and older, living in the service area.

b. Total the government paid portion for all claims.

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Attachment D

Total Expenses

Sum the total Inpatient and Outpatient expenses from each site to produce the Level of Effort.

Table 1. Institute for Defense Analysis (IDA) MEPRS Adjustments.

	ARMY %	NAVY %	AIR FORCE %	AVERAGE %
Construction	4.30	4.30	4.30	4.30
DMSSC	1.29	1.29	1.29	1.29
Mgmt, HQ	0.68	1.11	0.85	0.88
FAA-Reference Labs	0.39	0.39	0.39	0.39
FAH-Clinical Investigation[2]	0.71	0.22	0.71	0.55
FAK-Student Expense[1]	4.65	2.75	2.18	3.19
FAL-Continuing Health Ed[2]	1.17	1.14	0.90	1.07
Outpatient Total	13.2	11.2	10.6	11.7
FEA-Patient Transportation[2]	3.74	2.14	2.18	2.69
Inpatient Total	16.9	13.3	12.8	14.3

1. year of training; 100% for interns and residents before year 2. Excluded from the Medicare Demonstration Project as GME expenses.
2. Includes MEPRS accounts FEB and FEC. For treating facilities within demonstration areas, actual expenditures in these MEPRS accounts are allocated between Inpatient and Outpatient care and between Medicare and all other beneficiaries. For treating facilities outside of demonstration areas, the IDA percentages will be used.

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Attachment E—Medicare Demonstration of Military Managed Care

Evaluation

Medicare Demonstration Sample Evaluation Questions—These questions are among those which may be addressed in either the GAO report required by the demonstration project's authorizing statute or in a separate evaluation conducted jointly by the Department of Defense and the Department of Health and Human Services.

• Can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries?

The Medicare Demonstration should be able to answer the basic question of whether DoD and Medicare can meet its objective of implementing a cost-effective alternative for delivering care to dual-eligible beneficiaries through MHS. The answer to this question can be found by answering questions in four basic areas: enrollment demand, enrollee benefits, cost of the program, and impact on other DoD and Medicare beneficiaries for TRICARE Senior Prime and Medicare Partners. In each there should be a question about whether the demonstration succeeded and a set of analyses that examines the details within that area.

(1) Benefits for Enrollees

• Do dual-eligible beneficiaries benefit from Medicare reimbursement and enrollment in terms of quality, satisfaction, health status, access, or out of pocket costs?

• Will individual patients have better outcomes if treated as a DoD enrollee?

• Will beneficiaries as a whole evince better health and higher satisfaction when DoD enrollment is an option?

• Will beneficiaries have wider managed care choices?

• Will beneficiaries experience improved access to health care in general?

By definition, enrollees will have at least as generous a benefit as Medicare beneficiaries. The basic question will be: does DoD fulfill this promise and what if any additional benefits accrue to enrollees? However, the question will go much deeper than the structure of the prime benefit. Will beneficiaries as a whole experience better health, experience improved access, report higher satisfaction and encounter lower out of pocket costs when DoD enrollment is an option? In this case, we should examine the levels of satisfaction, health status, and access between those enrolled versus those not enrolled and between those in the demonstration areas versus those outside the demonstration areas.

As one measure of quality, DoD facilities are JCAHO accredited and the grid scores received will give us information on whether the MHS is maintaining its high standard of care. Data from the Health Care Survey of DoD Beneficiaries can be used to assess levels of satisfaction, access, and health status.

(2) Cost of Program

• Does Medicare reimbursement and enrollment occur without increasing the costs to either the Department of Health and Human Services and the Department of Defense?

• Will the Medicare Trust Funds experience losses or savings?

• Will the government as a whole experience losses or savings?

• What impact would Medicare reimbursement and enrollment have on the budgets of the Department of Health and Human Services and the Department of Defense?

Again, by definition, the demonstration must be budget neutral. However, the demonstration should provide an accounting that budget neutrality was achieved and that no cost were shifted from DoD to Medicare, i.e. that the Medicare trust funds did not experience any losses. This should include an analysis of the level of effort that DoD expends for the Medicare eligible as well as any reimbursements from Medicare that may be triggered during the demonstration. Analyses should also determine if DoD can in fact live within the Medicare payment, and whether its ability to live within it is determined by the level of the Medicare payment for different areas. In addition, the demonstration should highlight any cost shifting within the DoD to accommodate care for prime enrollees, both between regions and among medical programs. For Medicare Partners payments, analyses should estimate to what extent graduate medical education (GME), indirect medical education (IME), and disproportionate share hospital (DSH) amounts are included in those payments. It should also be able to forecast future budget impacts if the demonstration is continued or expanded.

Data for this section will be obtained in the same way that we estimated level of effort for reimbursement purposes. Sources include inpatient, ambulatory, and ancillary medical records and MEPRS accounting data. Because of the concern of shifting between regions and among medical programs, some level of aggregate data will need to be analyzed from outside the demonstration regions. Changes in Medicare expenditures to dual eligible beneficiaries could be accomplished with merged DoD and HCFA files similar to those being used for the initial level of effort analysis.

(3) Impact on Other DoD and Medicare Beneficiaries

• What impact (access, quality, cost) does Medicare reimbursement and enrollment have on medical care for DoD beneficiaries (active duty, active duty dependents, retirees and their dependents) other than the dual-eligible beneficiaries?

• Will the demonstration affect local health care providers or non-dual-eligible Medicare beneficiaries access to quality care?

The effect of the Medicare Demonstration may go beyond the effects on those who are Medicare eligible. Providing all inclusive care for Medicare eligibles may have effects on the access and priority of other beneficiaries in getting quality health care. The demonstration should provide answer to whether such a new benefit can be established without negatively impacting other classes of beneficiaries. In particular, the main focus of this question should be if access to non-Medicare eligible individuals has declined as a result of the demonstration. This should be examined for the different classes of beneficiaries and especially for active duty personnel and their dependents. The demonstration should also examine the effects of enrolling these individuals on CHAMPUS costs if they are displacing other beneficiaries in the direct care system.

Similar to (1) but for the remaining beneficiary categories, we propose using the Health Care Survey of DoD Beneficiaries to examine trends in access for non-Medicare eligible individuals.

(4) Enrollment Demand

• Is there sufficient demand to justify enrollment of and reimbursement for dual-eligible beneficiaries in TRICARE Senior Prime and/or Medicare Partners?

• What impact does Medicare reimbursement and enrollment have on the use of the Military Health System by dual-eligible beneficiaries?

• Will the Medicare Demonstration fare differently in different areas?

Up to this point, we do not know the degree to which Medicare eligibles are interested in participating in TRICARE Senior Prime and Medicare Partners. The demonstration should allow us to gauge the demand for such services. If few beneficiaries sign up, then one would question the need for such a program. Therefore, the basic question will be the number of Medicare Prime enrollees. We will also be interested on the total usage of the DoD system including space available use. Prior to the demonstration, beneficiaries fall into three categories: those who use the military system exclusively, those who use it for some of their health care, and those who rely exclusively on civilian care. With the demonstration, the first category will be split into two, those who enroll and those who use space available care for all their health care. The demonstration should seek the answer to who enrolls (e.g. are they prior exclusive users of DoD), what shifts between categories occurs, and does DoD continue to support at least as many beneficiaries as prior to the demonstration. It will also be of interest in projecting future enrollment to measure differences in enrollment between sites. Do those with greater military health care capability attract more enrollees than those with limited capability? Do civilian capabilities and alternatives influence the beneficiaries decision to enroll?

Data for this part of the evaluation will be from three sources. First, the enrollment files themselves will give us information on the number and kinds of beneficiaries who sign up for TRICARE Senior Prime. Second, the MHS User Survey can estimate the proportion of dual eligibles in each of the three categories. This data will also answer the questions as to what extent access of non-enrollees to space available care and pharmacy benefits are affected. Finally, the merging of utilization files from DoD and HCFA will give another look at what proportion of care is seen between the two systems.

DOD Performance Measures Attachment F—

Enrollment Systems

Performance: DoD provides appropriate enrollment information to HCFA; applications are handled according to HCFA requirements.

Criteria DoD can effectively interface with HCFA systems; applications are dated when received, handled first-come, first-served.

Grievance and Appeals

Performance: Process exists to handle beneficiary and provider complaints.

Criteria: DoD keeps an accurate log of complaints and addresses them promptly and appropriately.

Marketing

Performance: Process exists for assuring that beneficiaries are well-informed (beneficiaries are not misled, misrepresentations about the Medicare program are not made).

Criteria: DoD assures that beneficiaries are well informed, marketing materials are reviewed by HCFA before DoD distributes them.

Access/Capacity

Performance: DoD has adequate capacity and enrollees have adequate access to services.

Criteria: DoD demonstrates that TRICARE Senior Prime enrollees are getting the same priority and the same access as other military retirees who enroll in TRICARE Prime.

Paying Providers

Performance: Systems exist for processing payment to providers.

Criteria: DoD demonstrates ability to pay providers timely and accurately.

Reimbusement/Level of Effort

Performance: DoD has systems that receive and track payments from HCFA, and DoD can track actual costs for both space-available and enrollee care.

Criteria: DoD receives payment without problems; DoD demonstrates ability to track/allocate costs for space-available and enrollee care.

Encounter Data

Performance: DoD submits ''test'' data to fiscal intermediaries/carriers.

Criteria: DoD demonstrates successful data transmission.

[FR Doc. 98–19041 Filed 7–16–98; 8:45 am]

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DEPARTMENT OF EDUCATION

Notice of Proposed Information Collection Requests

AGENCY: Department of Education.

SUMMARY: The Acting Deputy Chief Information Officer, Office of the Chief Information Officer, invites comments on the proposed information collection requests as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before September 15, 1998.

ADDRESSES: Written comments and requests for copies of the proposed information collection requests should be addressed to Patrick J. Sherrill, Department of Education, 600 Independence Avenue, S.W., Room 5624, Regional Office Building 3, Washington, D.C. 20202–4651.

FOR FURTHER INFORMATION CONTACT: Patrick J. Sherrill (202) 708–8196. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Deputy Chief Information Officer, Office of the Chief Information Officer, publishes this notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g., new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment at the address specified above. Copies of the requests are available from Patrick J. Sherrill at the address specified above.

The Department of Education is especially interested in public comment addressing the following issues: (1) is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner, (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected, and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology.

Dated: July 13, 1998.

Hazel Fiers,

Acting Deputy Chief Information Officer, Office of the Chief Information Officer.

Office of Educational Research and Improvement

Type of Review: New.

Title: Third International Mathematics and Science Study Video—Repeat (TIMSS–R).

Frequency: On Occasion.

Affected Public: Individuals or households; not-for-profit institutions.

Reporting and Recordkeeping Hour Burden:

Responses: 5,600.

Burden Hours: 567.

Abstract: Videotape study of 8th grade math and science classrooms in the United States, the Czech Republic, France, Japan, the Netherlands, and One Asian Nation during the 1998–1999 school year. Designed and conducted by the U.S., this study supplements the Main TIMSS–R academic assessment data collection in which 45 to 50 countries are expected to participate. This study is based on and extends the work of the previous TIMSS video study. That study included only mathematics and compared the U.S. data with two other countries—Japan and Germany. This study will include science in addition to mathematics lessons, will be conducted in five high-achieving nations, and will collect and produce video tapes that will be useful for improving teaching practices.

Office of Educational Research and Improvement

Type of Review: Revision.

Title: The Blue Ribbon Schools Program.

Frequency: One time.

Affected Public: Not-for-profit institutions; State, local or Tribal Gov't, SEAs or LEAs.

Reporting and Recordkeeping Hour Burden:

Responses: 515.

Burden Hours: 25,750.

Abstract: The Blue Ribbon Schools award is a national school improvement strategy with a threefold purpose: (1) to identify and give public recognition to outstanding public and private schools across the nation; (2) to make available a comprehensive framework of key criteria for school effectiveness that can serve as a basis for participatory self-assessment and planning in schools; and (3) to facilitate communication and sharing of best practices within and among schools based on a common