

# U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

## Centers for Medicare & Medicaid Services

# MEDICARE WAIVER DEMONSTRATION APPLICATION



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**DISCLOSURE STATEMENT:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0880. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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# MEDICARE WAIVER DEMONSTRATION APPLICANT DATA SHEET

Applicant Legal Name		Date Submitted	
Address		Date Received by CMS	
City	County	State	ZIP Code

Name, telephone number and address of person to be contacted on matters involving the application.

Descriptive Title of Applicant's Project	Project Duration (mm/dd/yyyy) From _____ To _____
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Proposed Project

Type of Applicant

- Academic Institution     
  Individual     
  Profit Organization  
 Not for Profit Organization     
  Other, please specify \_\_\_\_\_

Areas Affected by Project (cities, counties, states)

Applicant's Medicare Provider Number(s)	Applicant's Employer Identification Number
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Is The Applicant a Medicare Provider/Organization in Good Standing?

- Yes   
  No   
 If "No," attach an explanation

To the best of my knowledge and belief, all data in this application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the terms and conditions of the award and applicable Federal requirements if awarded.

Type Name and Title of Authorized Representative	Telephone Number (include area code)
Signature of Authorized Representative	Date Signed (mm/dd/yyyy)

# MEDICARE WAIVER DEMONSTRATION APPLICATION

This application provides an opportunity for eligible organizations to apply to participate in Medicare-waiver-only demonstrations sponsored by the Centers for Medicare & Medicaid Services (CMS).

CMS conducts Medicare-waiver-only demonstrations to test innovations that have been shown to be successful in improving access and quality and/or lowering health care costs. These demonstrations may involve new benefits, fee-for-service or Medicare Advantage payment methodologies, and/or risk sharing arrangements that are not currently permitted under Medicare statute.

Section 402 of Public Law 92-603 grants CMS the authority to waive Medicare payment and benefit statutes to conduct these demonstrations. Demonstrations may also be initiated as a result of Congressional mandate.

## BUDGET NEUTRALITY

Medicare-waiver-only demonstrations must be budget neutral. Budget neutrality means that the expected costs under the demonstration cannot be more than the expected costs were the demonstration not to occur. Applicants must supply information and assumptions supporting budget neutrality that CMS will use in preparing a waiver package for submission to the President's Office of Management and Budget (OMB). OMB must approve Medicare waivers before implementing the demonstration.

## DUE DATE

Applications will be considered timely if we receive on or before the due date specified in the "DATES" section of the demonstration solicitation. Applications must be received by 5 P.M EST/EDT on the due date.

Only applications that are considered "timely" will be reviewed and considered by the technical review panel.

## APPLICATION SUBMISSION

An unbound original and 2 copies plus an electronic copy on cd-rom must be submitted. Please note that applicants may, but are not required, submit 10 copies to assure that each review panel member receives the application in the manner intended by the applicant (e.g., collated, tabulated, color copies, etc.).

The original and all copies, including the electronic copy, of the APPLICATION should be MAILED to the following address:

**Department of Health and Human Services, Centers for Medicare & Medicaid Services, ATTN: (Insert project officer name listed in demonstration solicitation and name of demonstration), Medicare Demonstrations Program Group, Office of Research, Development & Information, Mail Stop C4-17-27, 7500 Security Boulevard, Baltimore, Maryland, 21244.**

Applications must be typed for clarity in 12 point font and 1 inch margins and should not exceed 40 double-spaced pages, exclusive of the cover letter, executive summary, forms, and supporting documentation.

Because of staffing and resource limitations, and because we require an application containing an original signature, we cannot accept applications by facsimile (FAX) transmission.

## FOR FURTHER INFORMATION

Please contact the project officer listed in the demonstration solicitation and/or visit the CMS website at [www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage](http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage). Additional information about the demonstration, for example, fact sheets, design reports, solicitations, application materials, press releases, and question and answer documents will be periodically posted on the website. Be sure to check the website frequently if applying for a demonstration to be sure you have the most current information available.

# MEDICARE WAIVER DEMONSTRATION APPLICATION

## APPLICATION CONTENTS OUTLINE

To facilitate the review process, applications should be arranged in the following order:

1. Cover Letter
2. Medicare Waiver Demonstration Applicant Data Sheet
3. Executive Summary
4. Problem Statement
5. Demonstration Design
6. Organizational Structure & Capabilities
7. Performance Results
8. Payment Methodology & Budget Neutrality
9. Demonstration Implementation Plan
10. Supplemental Materials

CMS may provide start-up funds to cover implementation costs associated with the demonstration. If start-up funding is available, it will be announced in the demonstration solicitation. If requesting start-up funds, please include the Application for Federal Assistance Standard Forms 424 after the Medicare Waiver Demonstration Applicant Data Sheet in the application and indicate the amount of funds requested in the cover letter. The Application for Federal Assistance Standard Forms 424 can be found at [http://www.grants.gov/agencies/approved\\_standard\\_forms.jsp](http://www.grants.gov/agencies/approved_standard_forms.jsp)

## APPLICATION REQUIREMENTS

We will use all the information you submit in the application review process. For specific details regarding the demonstration for which you are applying, please refer to the solicitation. Your application must include the following information.

**Cover Letter:** Please be sure to identify the demonstration, indicate the target population and geographic location of the demonstration (for example, urban or rural), the CMS provider numbers assigned to the applicant, contact person, and contact information.

**Medicare Waiver Demonstration Applicant Data Sheet:** Complete, sign, date, and return the Medicare Waiver Demonstration Applicant Data Sheet found at the beginning of this application.

**Executive Summary:** Provide a 4 page summary of the key elements of the proposal (for example, Sections 4, 5, 6, 7, 8, 9 under “Application Contents Outline”).

**Problem Statement:** Describe Medicare’s current coverage and payment policy, and describe how or why changes to current policy would lead to reductions in Medicare expenditures or improvements in Medicare beneficiaries’ access to and/or quality of care. Provide local examples. Describe the policy rationale for the proposal, who will benefit and why, and any previous experience with the proposed intervention.

**Demonstration Design:** Describe the intervention including the scope of services covered and/or benefit design, and payment methodology including financial incentives and/or risk sharing arrangements. Indicate how eligible beneficiaries will be identified, targeted, and enrolled in the demonstration (if applicable).

If applicable, describe the study design. Identify the intervention and comparison groups, and how Medicare beneficiaries will be assigned to each group.

Describe the process for notifying beneficiaries about participation in the demonstration and provide copies of informed consent, and beneficiary notification and communication materials to be used.

# MEDICARE WAIVER DEMONSTRATION APPLICATION

**Organizational Structure & Capabilities:** Describe your governance structure, and management and clinical teams, and their prior success in implementing the proposed/similar intervention. Provide an organizational chart that describes the functional and reporting lines of major departments and/or entities.

Demonstrate that infrastructure exists to implement and carry out the demonstration project. Provide copies of reports from clinical, financial, and management information systems and describe how they will be used to support implementation.

Provide copies of applicable Federal and State licenses. Indicate if the applicant is a Medicare provider in good standing. Describe any other applicable accreditation, credentialing, and/or certification processes and results.

Provide documentation of your organization's financial viability that will enable it to participate actively and successfully in the demonstration; for example, a formal audit opinion from the past 3 years or the balance sheet from the past 3 years with a summary description. If there are any financial concerns, explain how your organization has resolved or will address these problems.

**Performance Results:** Describe your systems and processes for monitoring clinical, financial, and operational performance. Identify key metrics collected, provide quantitative performance results, and describe how you use this information to continuously improve quality, access and efficiency; correct deficiencies; and satisfy beneficiaries, providers, and/or payers.

**Payment Methodology & Budget Neutrality:** Please indicate the proposed payment amount and method. Proposed payments may be based on Medicare fee-for-service or Medicare Advantage rates, methodologies, or some combination, and may involve risk sharing.

Describe in detail any risk sharing arrangements. Provide a revenue and expense statement by year for the life of the demonstration.

Demonstrate that the proposed intervention is budget neutral. Provide expected, best, and worse case scenarios. Include all supporting cost effectiveness, evidence, and assumptions used for the calculations.

**Demonstration Implementation Plan:** Describe your implementation strategy, including tasks, resources, and timeline to implement the demonstration. Identify internal system and process modifications required to implement the demonstration. Describe your recruitment strategy and contingency plans for achieving beneficiary participation thresholds. Identify the individuals and staff responsible for implementing the demonstration and attach biographies.

**Supplemental Materials:** Include in this section copies of supporting materials requested or referenced throughout the application.

## EVALUATION PROCESS

We will convene technical review panels that may include outside experts, in addition to our staff to review all of the applications. Panelists will receive a copy of the application along with a technical summary. Panelists will be asked to numerically rate and rank the application using evaluation criteria contained in the demonstration solicitation.

Applicants should review the demonstration solicitation for the specific evaluation criteria to be used by panelists to assess proposals, as well as additional information on the evaluation process and selection of awardees.