CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 256 | **Date: JULY 30, 2004**

CHANGE REQUEST 3410

SUBJECT: Use of Group Health Plan Payment System/MMCS to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries under Section 721 of the MMA

I. SUMMARY OF CHANGES: CMS will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (section 721, MMA), in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional fee for service Medicare program.

In order to implement these large programs most efficiently, each of the programs will need to have a new option code developed by CMS in Medicare's Health Plan Maintenance System (HPMS)/Plan Information Control System (PICS). For the purpose of this document, we are referring to this code as "Option X". By adding a new option code, CMS will be able to pay the Chronic Care Organizations a fixed monthly amount for each fee-for-service beneficiary and all FFS claims will continue to be able to be processed under traditional Medicare payment rules. With the exception of how CMS is paying these organizations, beneficiaries participating in these programs will be considered covered under the traditional Medicare Fee For Service program for all other purposes. They are not restricted in any way as to how they receive their other Medicare services. In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, this CR will direct CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in this program. Because we are using the Group Health Plan system/MMCS to pay demonstration sites, when a provider makes an inquiry to certain CWF screens, it appears that the beneficiary is enrolled in an HMO, when they are, in fact, eligible for coverage under the traditional Medicare FFS program. As a result, under previous demonstrations that are similar to the Chronic Care Improvement Program, we have had numerous incidents of beneficiaries being denied services and/or told that they must first get a referral from their health plan, when no such referral is, in fact, required.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 256	Date: July 30, 2004	Change Request 3410

SUBJECT: Use of Group Health Plan Payment System/MMCS to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries under Section 721 of the MMA

I. GENERAL INFORMATION

A. Background: CMS will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (section 721, MMA), in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional fee- for service Medicare program.

In order to implement these large programs most efficiently, each of the programs will need to have a new option code developed in Medicare's Health Plan Maintenance System (HPMS)/Plan Information Control System (PICS). For the purpose of this document, we are referring to this code as "Option X"; however, the exact code is to be developed. This new code should only be one byte to conform to current CWF requirements. By adding a new option code, CMS will be able to pay the Chronic Care Organizations a fixed monthly amount for each fee-for-service (FFS) beneficiary and all FFS claims will continue to be able to be processed under traditional Medicare payment rules. With the exception of how CMS is paying these organizations, beneficiaries participating in these programs will be considered covered under the traditional Medicare Fee For Service program for all other purposes. They are not restricted in any way as to how they receive their other Medicare services. We will use this code beyond the Voluntary Chronic Care Program for similar organizations operating under demonstration authority.

In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, this CR will direct CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in this program. Because we are using the Group Health Plan system/MMCS to pay the Chronic Care Organizations, when a provider makes an inquiry to certain CWF screens, it appears that the beneficiary is enrolled in an HMO, when they are, in fact, eligible for coverage under the traditional Medicare FFS program. As a result, under previous demonstrations that are similar to the Chronic Care Improvement Program, we have had numerous incidents of beneficiaries being denied services and/or told that they must first get a referral from their health plan, when no such referral is, in fact, required.

Although we will also be doing provider education, due to the large number of people we expect to be participating in this large-scale program, we strongly believe that suppressing this information on the specified CWF inquiry screens for those organizations that have the new option code will substantially reduce beneficiary access problems and both provider and beneficiary confusion.

B. Policy: In order to implement this large MMA program most efficiently, each of the organizations will be set up as an "Option X Chronic Care Organization" in Medicare's Group Health Plan System/PICS, which is other wised used for Medicare Advantage (formerly Medicare + Choice) health plans. By identifying beneficiaries as belonging to an "Option X" Chronic Care Organization, CMS will be able to pay the organization a fixed monthly amount for each beneficiary but, as an "Option X" Chronic Care Organization, all fee for service claims will continue to be able to be processed under traditional Medicare payment rules. With the exception of how CMS is paying these organizations, beneficiaries enrolled in this program will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations. They are not restricted in any way as to how they receive their other Medicare services.

In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, this CR directs CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these programs. We need to ensure a new option code to be developed by CMS (HPMS/PICS). When that option code is indicated the CWF inquiry screen is to be suppressed for HMO information.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3410.1	CMS "HPMS/PICS" shall create a new option code for these programs.	HPMS/PICS
3410.2	CWF shall not display the HMO occurrence specifically for the option code developed above for Provider Inquiries HIQA, HIQH, HUQA, ELGA, ELGB, ELGH, and the HIPAA 271 response.	CWF
3410.2.1	If a beneficiary's "Current HMO Occurrence' is for Option Code X and there is also a 'Prior HMO Occurrence' that is not for Option Code X, then CWF shall display the 'Prior HMO Occurrence' in the 'Current HMO Occurrence'.	CWF

	(i.e., There shall not be a blank current occurrence line if there is a prior occurrence.)	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Raymond Wedgeworth at RWedgeworth@cms.hhs.gov **Post-Implementation Contact(s):** Raymond Wedgeworth at RWedgeworth@cms.hhs.gov	**These instructions shall be implemented within your current operating budget.**