CMS Manual System

Pub. 100-19 Demonstrations

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

Transmittal 4 **Date: May 14, 2004**

CHANGE REQUEST 3283

I. SUMMARY OF CHANGES:

CMS is conducting several large coordinated care, disease management, and other demonstrations under which private organizations will contract with CMS to provide specified services to beneficiaries enrolled in the traditional Fee-For-Service Medicare program. In order to implement these larger demonstration most efficiently, each of the demonstration organizations will be set up as an "Option 1 group health plan" in Medicare's Group Health Plan System which is otherwise used for paying Medicare Advantage (formerly Medicare + Choice) health plans. By enrolling beneficiaries in these "option 1" plans, CMS will be able to pay the demonstration plans a fixed monthly amount for the services they provide to each beneficiary but, as an "option 1" plan, 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 these demonstrations 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 directs CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these demonstrations.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 4, 2004
***IMPLEMENTATION DATE: October 4, 2004**

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 – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1 / Table of Contents

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Use of Group Health Plan Payment System to Pay Capitated Payments to Non Health Plan Demonstrations Serving Medicare Fee For Service Beneficiaries

I. GENERAL INFORMATION

A. Background:

CMS is conducting several large coordinated care,disease management, and other demonstrations under which private organizations will contract with CMS to provide specified services to beneficiaries enrolled in the traditional Fee For Service Medicare program. CMS will pay these contracting organizations a fixed monthly payment for each beneficiary they enroll to cover the cost of these services that are not otherwise covered under the traditional Medicare program. The demonstration organizations will not be paying any claims on behalf of enrolled members. Beneficiaries will continue to have all of their medical care paid for through the traditional Medicare program. Enrollment in any of these demonstration programs will not affect how a beneficiary's other Medicare claims are processed.

B. Policy:

In order to implement these larger demonstrations most efficiently, each of the demonstration organizations will be set up as an "Option 1 group health plan" in Medicare's Group Health Plan System which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans. By enrolling beneficiaries in these "plans" under Option 1, CMS will be able to pay the demonstration sites a fixed monthly amount for each beneficiary but, as an "option 1" plan, 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 these demonstrations will be considered covered under the traditional Medicare Fee For Service program for all other purposes. Beneficiaries will only receive coordinated care, disease management, or other special services from these special demonstration programs. 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 demonstrations.

Because new disease management, coordinated care, or other demonstration "plans" may be added to this demonstration periodically, the functionality to suppress "HMO" information for these plans shall allow updating with no more than 30 days notice.

C. Provider Education:

Although providers need not be informed about the details of all of these different demonstrations, all providers (including but not limited to hospitals, SNFs, home health agencies, DMERC, physicians, and others) need to be informed that beneficiaries enrolled in them are fully covered for all traditional Medicare Fee For Service benefits and that all of these beneficiaries claims will be process by the relevant Medicare fiscal intermediary, carrier, RHHI, or DMERC.

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
3283.1	Staff in CMS's Office of Research, Development & Information/Medicare Demonstrations Program Group shall provide to CWF a list of coordinated care/disease management demonstrations being paid as Option 1 health plans. ▪ Plans shall be identified by their "H" number. ▪ Attachment 1 lists the plans currently covered under these demonstrations.	CMS Staff
3283.2	CWF shall create and populate a reference table that can readily be updated listing all such demonstration plans. ▪ This table shall be able to be updated on a periodic basis without being tied to the standard quarterly release and release notification schedule. ▪ No more than 30 days shall be required to complete such updates.	CWF

3283.3	CMS Staff shall prepare a recurring CR to communicate whenever the table is required to be updated.	CMS Staff
3283.4	CWF shall not display the HMO occurrence specifically for the HMO Plan ID that is on the HMO table for Provider Inquiries HIQA, HIQH, HUQA, ELGA, ELGB, ELGH, and the HIPAA 271 response.	CWF
3283.5	If a beneficiary's "Current HMO Occurrence' is for an HMO Plan ID that is on the HMO table and there is also a 'Prior HMO Occurrence' for that beneficiary for an HMO Plan ID that is not on the HMO table, then CWF shall display the 'Prior HMO Occurrence' in the 'Current HMO Occurrence' row. (i.e. There shall not be a blank current occurrence line if there is a prior occurrence.)	CWF

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: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** Jody Blatt (410-786-6921) or Amy Knight (410-786-2307) **Post-Implementation Contact(s):** Amy Knight (410-786-2307)	**These instructions shall be implemented within your current operating budget.**

Attachment 1

Demonstrations Being Paid As 'Option 1' Health Plans in the Group Health System

H1902	Cor Solutions
H4519	XL Health, Inc.
H5408	Pacificare/SeniorCo (on behalf of HeartPartners Group)