Medlearn Matters
Information for Medicare Providers

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Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries

Provider Types Affected

All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a four-state Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Programs that are currently enrolling beneficiaries are: CorSolutions in Lousiana; XLHealth in Texas; and HeartPartners in California and Arizona.

These Disease Management Organizations are not HMOs, but are being paid, using the CMS Group Health System, a fixed monthly payment for disease management services as an "Option 1" cost plan. All Fee-For-Service claims will continue to be processed under traditional Medicare payment rules. Beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare Fee-For-Service program. Participants in the demonstration are not restricted in any way as to how they receive their other Medicare services.

The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-For-Service beneficiaries. No referrals for care are needed and all Fee-For-Service claims will be processed under traditional Medicare payment rules.

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated this demonstration to evaluate how disease management services, combined with a prescription drug benefit, can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease.

Up to 30,000 eligible Medicare Fee-For-Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in California, Arizona, Louisiana, and Texas.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

Participants will be assigned to either a disease management group or a usual care group. The disease management group will receive disease management services and prescription drug benefits in addition to their usual Medicare benefits at no additional cost except for a modest co-payment for prescription drugs. All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Locations

Louisiana - CorSolutions will be providing services to 5,000 Medicare beneficiaries with congestive heart failure, diabetes, and/or coronary heart disease residing in the Shreveport – New Orleans corridor of Louisiana. (Questions? Call 1-800-917-2204).

Texas - XLHealth will be providing services to 10,000 Medicare beneficiaries with congestive heart failure (CHF), cardiovascular disease (CVD), or diabetes with co-morbidities of CHF, CVD or lower extremity complications in Texas. (Questions? Call 1-888-284-0001).

California and Arizona - HeartPartners℠ (collaboration among PacifiCare Health Systems, Qmed, and Alere Medical) will be providing services to 15,000 Medicare beneficiaries with congestive heart failure in California and Arizona. (Questions? Call 1-866-242-3432).

Medicare Common Working File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, the Common Working File screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan. The definition of "Option 1" means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program.