Medicare Health Support Program
General FAQs

Is the sample size sufficient to reach statistically significant financial conclusions?
The size of the population is consistent with the statutory requirement of having a control group of at least 10,000 beneficiaries per program. Statistical calculations ("power calculations") were done prior to the specification of the population size to assure that there would be sufficient sample size to evaluate the program with respect to achieving the original financial target of saving 5% net of fees. Since the revised financial target of budget neutrality has been approved, the independent evaluator has reviewed its calculations and is confident that there is still sufficient sample size to conduct the financial analyses for the evaluation. The financial reconciliation does not rely on statistical testing, so sample size is not an issue for that task.

Were the intervention and control groups equivalent at the time of program start-up?
In the first Report to Congress (June 2007), the independent evaluator confirmed that the randomization procedure produced similar demographic, disease, and economic burden profiles between the intervention and comparison groups at the time of randomization. However, between the time of randomization and the start date, there were some unanticipated cost differences. Most of the differences in costs are attributed to beneficiaries who died between randomization and start-up, as end of life costs can be extremely high. To address the differences, the CMS provided the MHSOs with an actuarial adjustment, which the organizations can choose to accept or decline. This statistically adjusts the historical financial disparities between the intervention and comparison population, essentially making the adjusted costs of the intervention and comparison groups equal as of the program start date.

Was there any incorrect identification and/or incorrect exclusion of participants (e.g., wrong diagnoses on claim) in the intervention group that could impact Phase I?
Beneficiaries were identified as eligible for the program based on diagnoses reported on Medicare claims. The CMS made MHSOs aware prior to program start that using administrative data such as claims does not guarantee that the identified individuals have clinically confirmed heart failure or diabetes (the threshold conditions for participation in MHS). This "false positive" identification would impact both the intervention and the comparison populations. Additionally, since the goal of MHS is to manage the whole person, not just to address their needs with respect to a single chronic condition, these beneficiaries were still expected to benefit from the care management program.

Did lack of initial access to many high cost beneficiaries impact Phase I?
The CMS provided the MHSOs with the best available contact information for the beneficiaries eligible to participate in MHS. Each MHSO had its own approach to beneficiary outreach and enrollment. Some organizations were more successful at gaining participation from their assigned beneficiaries than others. The first Report to Congress notes that participation rates in the first 6-month period ranged from 65% to 92%.

The statutory provision that established Medicare Health Support (Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) authorized the expansion (under Phase II) of programs or program components that are found by an independent evaluation to have met the conditions for expansion. If a Phase II is initiated, how will intervention models be selected for that Phase?
Eight different MHS programs were implemented under Phase I, five of which are still in operation. Each program was designed to test different interventions and methodologies. If a Phase II is initiated, the CMS may include any programs or program components that met the conditions for expansion. However, Phase II awardees would be selected according to a new competitive process. Participation in Phase I would not guarantee an organization participation in Phase II.

What are some examples of program components?
There are 16 different program components offered to beneficiaries with diabetes or heart failure, which are being evaluated in Phase I. In addition, each of the Phase I programs offers separate program components for beneficiaries with heart failure and for beneficiaries with diabetes.

Does the definition of a program mean that MHSO A is the same as a program?

No. A program is defined as the interventions and the methodology employed by one or more MHSOs offered to the beneficiaries in Phase I of MHS. MHSO "A" may offer a program in Phase I; however, the independent evaluation evaluates whether a program, not MHSO "A", meets the conditions for expansion.

Are there only two threshold conditions for which services could be expanded to Phase II?
Yes, they are heart failure and diabetes, the two threshold conditions being tested in Phase I.

Why not consider chronic obstructive pulmonary disease (COPD) as a threshold condition for a potential Phase II? It is mentioned as a possible target population in the statute.
Only a program or program component that was tested in Phase I and meets the conditions for expansion may be considered for Phase II. Since COPD is not being tested in Phase I, it cannot be included as a threshold condition should there be a Phase II expansion.

When will the Reports to Congress (RTCs) and independent evaluation be completed?
The statute required several RTCs, due by the following dates:

- August 2007 [available at http://www.cms.hhs.gov/Reports/Downloads/McCall.pdf]
- February 2009
- February 2011
- February 2013

The independent evaluation is ongoing and will be completed after all the Phase I programs have ended.

What is the difference between the Reports to Congress (RTCs) and the Independent Evaluation?

The RTCs are the documents by which the Secretary informs Congress of the Program. The independent evaluation is an ongoing assessment of the Phase I program and will be used to inform the Secretary of each program's or program component's ability to meet the conditions for expansion.