Medicare Learning Network
MLN Matters
CMS Centers for Medicare & Medicaid Services
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM3410
Related Change Request (CR) #: 3410
Related CR Release Date: July 30, 2004
Effective Date: January 1, 2005
Related CR Transmittal #: 256
Implementation Date: January 3, 2005

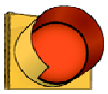
MMA - Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA

Note: This article was revised to contain web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Providers Affected

Physicians, providers, and suppliers

Provider Action Needed

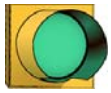


STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721 of the Medicare Modernization Act (MMA)) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional Fee-For-Services (FFS) Medicare program.

CAUTION – What You Need to Know

With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs 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 and they are not restricted in any way on how they receive their other Medicare services.



GO – What You Need to Do

See the *Background* and *Additional Information* sections of this article for more information on this notification.

Background

This instruction notifies providers that 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 FFS Medicare program.

In order to implement these large programs most efficiently, CMS plans to accomplish the following:

- Each program will be assigned a new option code (designated as "Option XX" in this instruction); and
- Each organization will be set up as an "Option XX Chronic Care Organization" in Medicare's Group Health System/PICS, which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans.

By enrolling beneficiaries in these "Option XX" Chronic Care Organizations, CMS will be able to pay the organizations a fixed monthly amount for each beneficiary. Also, as an "Option XX" Chronic Care Organization," CMS can continue processing all FFS claims under traditional Medicare payment rules.

With the exception of how CMS is paying these organizations, beneficiaries enrolled in these programs 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 on how they receive their other Medicare services.

Because the Group Health Plan system/MMCS is being used to pay demonstration sites, when a provider makes an inquiry to certain Common Working File (CWF) screens, it appears that the beneficiary is enrolled in a Health Maintenance Organization (HMO), when they are eligible for coverage under the traditional Medicare FFS program.

In order to avoid this confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, this instruction directs the CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these programs.

In the event the provider is advised by the beneficiary or through some other means that the beneficiary is enrolled with one of these Chronic Care Organizations, the providers should treat the beneficiary an ordinary FFS beneficiary who requires no referral from the Chronic Care Organizations in order to receive services in a FFS setting.

Implementation

The implementation date for this instruction is January 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier or fiscal intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/Downloads/R256CP.pdf on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.