FACT SHEET

COMPLETION OF PHASE I OF MEDICARE HEALTH SUPPORT PROGRAM

Overview

The Centers for Medicare and Medicaid Services (CMS) announced today that Phase I of the Medicare Health Support (MHS) program will end after three years of operations by five Medicare Health Support Organizations (MHSOs).

The MHS program was established in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) as a two-phased initiative. MHS Phase I is a three year pilot program designed to test a variety of care management interventions to invited fee-for-service Medicare beneficiaries with heart failure or diabetes. Phase II would expand the program based on findings from Phase I.
The Secretary of Health and Human Services (HHS) is authorized to expand the MHS program under Phase II if the results of an independent evaluation specify that a participating program (or component of a program) meets all the statutory criteria for expansion. Those criteria include improvement in clinical quality and beneficiary satisfaction, and the achievement of savings targets (at minimum, budget neutrality).

Preliminary evaluations of the MHS program indicate that Phase I of the program is not meeting the statutory requirements. The CMS will determine whether to expand the pilot into Phase II if the results of the independent evaluation indicate that any of the programs (or program components) meet the conditions for expansion as specified in statute.

There are currently 68,000 beneficiaries participating in the MHS program who will be notified by their MHSO about the ending of Phase I. These beneficiaries will continue to be covered under the traditional fee-for-service Medicare program.

Background

Section 721 of the MMA required the development and testing of voluntary chronic care improvement programs (CCIP), now called Medicare Health Support, to improve the quality of care and life for people living with chronic conditions. The programs are designed to help participants adhere to their physicians' plans of care and to learn and maintain healthy self-care behaviors to reduce their health risks. Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures. By better managing and coordinating the care of these beneficiaries, the MHS program is intended to reduce health risks, improve quality of life, and provide savings to the Medicare program (at minimum, budget neutrality). MHS is overseen by CMS and operated by organizations selected through a competitive award process. Nine organizations received MHS program awards in 2004; eight sites became operational in 2005 and 2006 (one awardee chose not to participate in MHS). Five MHSOs remain active and are scheduled to complete their pilot operations between July and December 2008.

Status of Phase I Program Operations

Active Phase I MHSOs and Regions Served:

- **Aetna Health Management** (started 9/1/2005, ends 8/31/2008): *Northern Illinois* including Cook, DuPage, Lake, McHenry, Kane, Will, and Kankakee counties.
- **Healthways, Inc.** (started 8/1/2005, ends 7/31/2008): *State of Maryland* and the *District of Columbia.*
- **Health Dialog Services Corporation** (started 8/15/2005, ends 8/14/2008): *Western Pennsylvania* including Forest, Clarion, Jefferson, Clearfield, Butler, Armstrong, Indiana, Cambria, Blair, Bedford, Somerset, Fayette, Westmoreland, Greene, Washington, Alleghany, Mercer, and Beaver counties.
- **Green Ribbon Health (**started 11/1/ 2005, ends 8/15/2008): *Central Florida* including Hillsborough, Pinellas, Manatee, DeSoto, Sarasota, Charlotte, Lee, Hardee, and Collier counties.
- **XLHealth Corporation** (started 1/1/2006, ends 7/31/2008): *West Tennessee* including Shelby, Fayette, Tipton, Haywood, Madison, Henderson, Crockett, Gibson, and Carroll Benton counties. *Middle Tennessee* including Humphreys, Hickman, Williamson, Rutherford, Dickson, Cheatham, Davidson, Wilson, Montgomery, Robertson, Sumner, Putnam, Cumberland, and Smith counties. *East Tennessee* including Marion, Sequatchie, Hamilton, Bradley, McMinn, Meigs, Blount, Anderson, Loudon, Knox, and Roane counties.

As CMS gained experience with the MHS program, several program modifications were made. The two most significant examples are:

- Phase I Financial Savings Targets: CMS and the MHSOs originally negotiated and included a 5 percent savings target net of fees for the MHS program. The MHSOs subsequently requested that the savings target be reduced to budget neutrality across the three year pilot program. The request was approved in December 2007.

- Randomization: In the first Report to Congress (June 2007; available at http://www.cms.hhs.gov/Reports/Downloads/McCall.pdf), the independent evaluator confirmed that the randomization procedure produced similar demographic, disease, and economic burden profiles between the intervention and comparison groups. However, between the time of randomization and the start date, there were some unanticipated cost differences. Most of the differences in costs were attributed to beneficiaries who died between randomization and start-up, as the deceased beneficiaries had extremely high costs towards the end of life. To address these differences, CMS provided actuarial adjustments to account for the resulting historical financial disparities between the intervention and comparison groups.

Preliminary Phase I Findings

The experience of the MHS program indicates that Phase I of the program is not meeting the statutory requirements of improved clinical quality outcomes, improved beneficiary satisfaction, and the achievement of financial savings targets. Based on the results of the independent evaluation of all of the Phase I programs, CMS will consider whether to expand to Phase II.

One of the goals of the MHS program is to see a reduction in Medicare claims costs for the intervention group. To date there has been nominal impact on Medicare claims costs as a result of the MHS program. At the level of individual organizations, some MHS programs show increases while others show modest decreases in Medicare claims costs. However, to achieve budget neutrality, the five MHSOs in current operation need to reduce Medicare claims costs by between $300 and $800 per participant per month for the remaining months of the pilot program. This represents a 20 to 40 percent reduction in claims costs from the current levels that are being billed. Program-wide fees paid to the MHSOs to date total approximately $360 million—an increase of 5 to 11 percent in Medicare costs for participating beneficiaries. Total operational costs to date to CMS are estimated at approximately $27 million.

CMS remains committed to exploring strategies that improve the health and well being of beneficiaries with chronic conditions. A great deal has been learned from MHS Phase I, which will be applied to future efforts to improve the quality of care for beneficiaries with chronic conditions and to save resources for the Medicare Trust Fund.

Impact on Participating Medicare Beneficiaries

There are currently 68,000 beneficiaries participating in the MHS program. Prior to the initiation of the MHS program these beneficiaries received all of their Medicare benefits through the traditional fee-for-service program. The MHS program provides the MHSOs with an additional care management fee in exchange for care management services that were hoped to result in cost savings at least equal to the care management fee and improve quality of care and beneficiary satisfaction. When Phase I ends these beneficiaries will no longer be receiving the care management services provided by the MHSOs. However, beneficiaries enrolled in the MHS program will continue to be covered under the traditional fee-for-service Medicare program and to receive all of the same benefits provided to other Medicare beneficiaries.

Next Steps

The first MHSO to complete its three year award period will end July 2008, and the last one will end in August 2008. CMS will continue to monitor and evaluate these programs to incorporate all results through the completion of Phase I. The results of the independent evaluation will be used to determine if a program (or program component) meets the statutory conditions for expansion. If CMS does move to a Phase II, the 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.

For additional information, frequently asked questions are posted at:
http://www.cms.hhs.gov/CCIP/downloads/MHSEOPexfaqsfin012808_FINAL.pdf