January 29, 2008

Completion of Phase I of Medicare Health Support Program
FAQs

How many beneficiaries will be affected by the end of Phase I and how?
There are currently 68,000 participants in the Medicare Health Support (MHS) program. Prior to beginning in MHS, these beneficiaries received all of their Medicare benefits through the traditional fee-for-service program. Under the MHS program, the CMS pays the Medicare Health Support Organizations (MHSOs) an additional care management fee to provide care management services. When MHS Phase I ends these beneficiaries will no longer receive the care management services provided by the MHSOs. However, beneficiaries enrolled in MHS programs will continue to be covered under the traditional fee-for-service Medicare program and receive all of the same benefits provided to other Medicare beneficiaries. Program participants will receive an "end of Phase I" notification from their MHS program.

Will beneficiaries be able to continue to access MHS services while the CMS is evaluating Phase I?
No, once Phase I ends beneficiaries will no longer have access to MHS services. The statute limits Phase I to three years and makes expansion to Phase II contingent on a program (or components of such program) improving the clinical quality of care, improving beneficiary satisfaction, and achieving targets for savings. Unless all three of those conditions are met, there is no authority to begin Phase II. There is also no provision for continued services under Phase I after the three year pilot ends.

What will the MHSOs have to save in order to be budget neutral by the end of Phase I?
The CMS estimates that the five remaining MHSOs need to reduce Medicare claims costs by between $300 and $800 per participant per month for the remaining months of the pilot program. This translates into roughly a 20-40% reduction in claims costs.

If the independent evaluation finds that a Phase I program meets the conditions for expansion under Phase II, would that decision be reached in time for the program to continue operations without a gap in services?
The CMS will continue to monitor and evaluate each MHS program to incorporate all results through the completion of Phase I. No decision regarding expansion of any program will be made until the evaluation indicates that the conditions for expansion have been met. If the CMS does initiate 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.

Given the recent decision to replace the original 5 percent savings target with budget neutrality, why is the CMS making the decision to end the Medicare Health Support Program?
The CMS and the MHSOs originally negotiated and included a 5 percent savings target net of fees for the MHS programs. The MHSOs subsequently requested that the savings target be reduced to budget neutrality (the minimum standard required by statute) across the three year pilot program. This request was approved. However, this decision does not affect the three year limit set by statute for Phase I of Medicare Health Support.

Could the CMS extend Phase I of the MHS program?
The statute only provides for an expansion of the program under Phase II. There is no provision to extend the time for current Phase I programs.

How will the Secretary decide whether to expand the MHS program to Phase II?
The Secretary will use the results of the independent evaluation to determine if any program or program component meets the statutory conditions for expansion. These conditions are: improving the clinical quality of care, improving beneficiary satisfaction, and achieving targets for savings.

When will the Secretary make a decision regarding Phase II expansion based on the independent evaluation results?
The decision to expand to Phase II will be made after the independent evaluation and the statutory conditions for expansion have been met. The evaluation is ongoing.