



Related MLN Matters Article #: MM3410

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Related CR #: 3410

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

Key Words

MM3410, CR3410, R256CP, Chronic CWF, MMA, GHP, Group Health, FFS, Fee-for-service

Provider Types Affected

Physicians, providers, and suppliers

Key Points

- The effective date of the instruction is January 1, 2005.
- The implementation date is January 3, 2005.
- MLN Matters article MM3410 notifies providers that the Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721, Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003).
- Under the Voluntary Chronic Care Improvement Program, private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional Fee-for-Service (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 Code 4” in Change Request (CR) 3410); and
 - Each organization will be set up as an “Option 4 Chronic Care Organization” in Medicare’s Group Health System/ Plan Information Control System (PICS), which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans.
- By enrolling beneficiaries in these “Option Code 4” Chronic Care Organizations, CMS will be able to pay the organizations a fixed monthly amount for each beneficiary.

- As an “Option Code 4” Chronic Care Organization,” CMS can continue processing all FFS claims under traditional Medicare payment rules.
- Beneficiaries will only receive coordinated care/disease management services from these Chronic Care Organizations.
- 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.
- Because the Group Health Plan system (Medicare Managed Care Systems (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.
- To avoid this confusion about a beneficiary’s access to services when providers or others check beneficiary eligibility on CWF provider inquiries, CR3410 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 as an ordinary FFS beneficiary who requires no referral from the Chronic Care Organizations to receive services in a FFS setting.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3410.pdf> on the CMS website.

The official instruction (CR3410) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R256CP.pdf> on the CMS website.

If providers have any questions, they may contact their carrier/fiscal intermediary (FI) at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.