



Disease Management Association of America

## Medicare Health Support Phase II: Beneficiary Eligibility

### DMAA Position

In order to ensure that the Medicare Health Support program best meets the chronic care and co-morbidity needs of the Medicare fee-for-service population, DMAA advocates that the Secretary of Health and Human Services define the inclusion criteria for beneficiary eligibility as broadly as possible.

### Background

Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which authorized the Medicare Health Support pilot program, required Phase I chronic care improvement programs to focus on targeted beneficiaries with one or more threshold conditions. These conditions were described in the law. Specifically, the statute stated, “[t]he term ‘threshold condition’ means a ‘chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD) or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program’ (now known as Medicare Health Support, or MHS, program). In addition, the target beneficiaries must be entitled to receive Medicare benefits under part A and be enrolled under part B, but not enrolled under Part C; have one or more of the threshold conditions; and have been identified as a potential participant for a MHS program.

In the solicitation notice, titled “Voluntary Chronic Care Improvement Under Traditional Fee-for-Service Medicare Request for Proposals” and published in the *Federal Register* on April 23, 2004, the Centers for Medicare and Medicaid Services (CMS) said that for Phase I, the agency would initially focus on “beneficiaries who have congestive heart failure (CHF) and/or complex diabetes, or chronic obstructive pulmonary disease (COPD) because they are major population subgroups within Medicare with significant health risks and disproportionately high health care costs that are not being consistently well managed.” Ultimately, contracts awarded under MHS addressed only CHF and/or complex diabetes.

CMS officials have clearly stated public forums that the choice of the two initial disease states does not indicate a long-term preference for them specifically.<sup>1</sup> Rather, these chronic illnesses were representative of the type of complex, high-cost and impactable conditions where solid clinical evidence existed, and where efforts in other payer sectors had shown results.

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<sup>1</sup> Speaking on March 9, 2005 to the Association of Community Cancer Centers (ACCC) about Medicare Health Support, CMS Administrator Mark McClellan stated, “Once this pilot program is shown effective, it may be expanded nationwide and expanded to include cancer care.”

Finally, CMS specifically excluded beneficiaries enrolled in the Medicare End-Stage Renal Disease (ESRD) program, hospice, Medicare Advantage, or any other CMS fee-for-service (FFS) chronic care demonstration.

### **DMAA Position Rationale**

CMS acknowledges that a small percentage of the Medicare population with chronic conditions account for a disproportionate amount of Medicare expenditures. Currently, almost one-half of Americans (about 133 million people) live with a chronic condition, and the prevalence of multiple chronic conditions increases as people age. According to a report of the Johns Hopkins University Partnership for Solutions, two out of three people aged 65 and older have multiple chronic conditions; and among people age 80 and older, 92 percent have at least one chronic condition and 73 percent have two or more. Two-thirds of Medicare spending is for people with five or more chronic conditions. (September 2004). People with multiple chronic conditions have more physician visits, see multiple physicians and other health care providers, fill more prescriptions, and have more hospitalizations.

DMAA advocates that in considering beneficiary eligibility and selection criteria in Phase II, CMS consider all of the factors impacting beneficiaries' needs. DMAA believes that Phase II programs should be suited to the needs of chronically ill fee-for-service beneficiaries who have unique and complex needs, stemming from their diagnosis or diagnoses, the combination of chronic conditions they live with, and possibly from characteristics associated with their geographic location. For example, a chronically ill individual living in a very rural setting may face different challenges than another individual in an urban or suburban setting with respect to availability of services and access to care. DMAA member organizations have proven success in adapting disease and care management programs for a variety of population needs and requirements.

Further, disease and care management inherently addresses the treatment of a whole person, who may have multiple chronic conditions and co-morbidities, and who is at risk for hospitalizations and other complications. In Phase I, though organizations were expected to support beneficiaries in a holistic manner, taking into consideration multiple co-morbidities, beneficiary selection criteria were based on single conditions. DMAA encourages beneficiary eligibility *criteria* that focus on the holistic care management approach. This approach could include simply the addition of other primary disease states, such as coronary artery disease (CAD), chronic obstructive pulmonary disorder (COPD), asthma, and/or depression, all of which are appropriate for chronic care/disease management services and which have the potential for national roll-out.

CMS, through the program solicitation notice and in public messages, has made clear its expectation that participating organizations will possess the ability to deal with the needs of the chronically ill in a holistic way. Both CMS and DMAA recognize that a beneficiary with a chronic disease, such as CHF, does not exist in a silo and may have multiple chronic conditions, further complicated by a range of co-morbidities, creating a

continuum of risk and care needs. Continuing the “single disease state” criteria approach in Phase II may not adequately take these factors into consideration. For Phase II, DMAA will collaborate with CMS to design programs responsive to the large population of chronically ill Medicare beneficiaries in need of disease or care management for a broader range of conditions.

As MHS programs continue to demonstrate success in improving quality and outcomes, and achieve Medicare savings, both CMS and DMAA will continue to support approaches that address these chronic care needs in a coordinated manner, in order to contain Medicare expenditures for duplicative or unnecessary care; to be more focused on improved outcomes for these individuals; and to establish disease and care management as a vital component of the Medicare program.