



Center for Medicaid and State Operations

SMDL #04-002

February 25, 2004

Dear State Medicaid Director:

Disease management represents an exciting opportunity to significantly improve the care delivered to Medicaid beneficiaries with chronic conditions. It has emerged in both the public and private sector as a strategy to bring the benefits of care coordination techniques honed in managed care organizations (MCOs) to populations and regions that traditionally have not had access to those comprehensive capitated systems.

This letter provides guidance on how states can cover disease management in their Medicaid programs. This letter outlines some of the more common options; states interested in other strategies should contact us for assistance.

Background

Disease management is a set of interventions designed to improve the health of individuals, especially those with chronic diseases. Disease management programs usually include:

- identification of patients and matching the intervention with need;
- support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist the physician in monitoring the patient;
- services designed to enhance patient management, and adherence to an individualized treatment plan (e.g., patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes);
- routine reporting and feedback loops (may include communication with patient, physician, health plan and ancillary providers, and practice profiling); and
- collection and analysis of process and outcome measures.

Traditionally, disease management was part of the comprehensive care furnished by MCOs. Today, we are seeing a multitude of strategies in order to bring disease management to fee-for-service (FFS) populations. States are building comprehensive systems in-house or contracting out the function to Disease Management Organizations (DMOs). This letter outlines some of the options available to states with regard to designing and operating disease management programs.

Disease Management as a Medical Service

Disease management programs that focus interventions on the beneficiary may qualify as medical services under Medicaid. In order to qualify as a medical service, disease management must include direct services. Direct services require the use of licensed practitioners such as nurses, pharmacists, or physicians who provide services directly to individual beneficiaries in order to improve or maintain their health. Examples include medical assessments, disease and dietary education, instruction in health self-management, and medical monitoring. These medical state plan services are eligible for Federal financial participation at the state's regular Federal Medical Assistance Percentage rate. Each proposal will be assessed to determine whether it qualifies as a medical service or administrative function, which in turn determines the Federal matching rate. There are a number of disease management models that may qualify as medical services under Medicaid, and we outline three major ones below.

Disease Management through Contracting With a Disease Management Organization (DMO)

One model is to contract with a DMO. The DMO manages the overall care of the beneficiary, but does not actually prior authorize or otherwise restrict access to other Medicaid services. In this model, the state often requires performance guarantees, including capitating the DMO for disease management services, as well as putting the DMO at risk for reducing overall expenditures. Capitated DMOs qualify as Prepaid Ambulatory Health Plans and are subject to a limited subset of the managed care regulations at 42 CFR Part 438.

Disease Management through an Enhanced Primary Care Case Management (PCCM) Program

A second model of beneficiary-focused disease management is to enhance a PCCM managed care program. In these programs, the state works with PCCM providers to enhance the care it delivers to its enrollees with certain chronic conditions. The state also may provide additional support in the form of case managers for complex cases and furnish ongoing monitoring reports on enrollee utilization. PCCM providers are often paid enhanced case management fees for providing disease management, in addition to the regular FFS reimbursement for other state plan services they provide.

Disease Management through Individual Providers

States can also offer disease management through individual FFS providers in the community (e.g., physicians, pharmacists, or dietitians). The providers often agree to undergo specified training, and bill on an FFS basis for disease management services provided. States may simply offer this option to interested providers, or build a more comprehensive system that provides additional support, training, and oversight.

Operating Authorities

All of the above models can be authorized through state plan amendments (SPAs) or waivers. Waiver authority can provide states with greater flexibility to design more focused programs. For instance, states that want to limit the number of disease management providers in order to achieve better cost and administrative efficiencies may request selective contracting authority under section 1915(b)(4) of the Social Security Act (the Act). Waiver authority also can be used to intentionally restrict geographic areas where disease management is available; restrict eligible beneficiaries (e.g., exclude Medicare beneficiaries); or mandate beneficiary enrollment.

Additionally, a SPA authorized under section 1932(a) of the Act provides much of the same flexibility available under waivers, and also does not require the periodic renewals associated with programs operating under waiver authority. This SPA authority to mandate enrollment was created by the Balanced Budget Act of 1997 and applies to PCCM or MCO-model disease management programs. As with waiver authority, section 1932(a) SPA authority provides flexibility with respect to limiting providers, eligible populations, and geographic areas that is not normally available under traditional SPAs. In particular, states offering disease management delivered as part of an enhanced PCCM program may want to consider this option.

A SPA may authorize disease management activities through expansions of the covered benefits for “other licensed practitioners” or “preventive services,” as appropriate. A disease management SPA must meet the requirements of section 1902(a) of the Act, including statewideness, comparability, and freedom of choice. These requirements apply to both capitated and FFS disease management providers.

Disease Management as an Administrative Function

A disease management program that is limited to administrative activities by the state and its contractors would not constitute “medical assistance,” but could be eligible for Federal matching funds for administration of the State plan at the standard administrative matching rate of 50 percent. For example, states or their contractors (e.g., a Quality Improvement Organization, Pharmacy Benefits Manager, or other outside vendor) may work with providers to: promote adherence to evidence-based guidelines; improve provider-patient communication skills; and provide routine feedback on beneficiary utilization of services. In this model, contact with beneficiaries is indirect: the change in provider practice patterns enhances beneficiary care. In addition, there may be targeted mailings to beneficiaries, but no face-to-face contact. The examples here are generally considered administrative functions, and may be eligible for Federal administrative match. State plan requirements such as statewideness and comparability do not apply to administrative functions.

Funding from Outside Sources

Pharmaceutical manufacturers may offer to fund disease management programs for Medicaid beneficiaries. Such funding would be considered a supplemental rebate under section 1927 of the Act, and, in accordance with the September 18, 2002, State Medicaid Director letter, the state needs to report an offset in the amount of Federal funds claimed based on the value of what the state received from the manufacturer.

Dual Eligibles

In general, disease management is not a Medicare-covered service. As a result, states may voluntarily or mandatorily enroll dual eligibles into a Medicaid disease management program. This is because in either case, enrollment does not affect their access to Medicare services. When enrolling dual eligibles, states must ensure that Medicare is the primary payer with respect to the limited Medicare coverage of diabetes self-management training sessions, and when disease management is available through a Medicare demonstration (please see the CMS Web site at <http://cms.hhs.gov/healthplans/research>).

For Further Information

We are available to provide technical assistance to states interested in establishing disease management programs for their populations. We encourage states to take advantage of the opportunities disease management programs offer to provide coordinated, cost-effective care that improves the health of Medicaid beneficiaries. If you have any questions about providing disease management, please call Ms. Jean Sheil, Director of the Family and Children's Health Programs Group at (410) 786-5647, or e-mail her at jsheil@cms.hhs.gov.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

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