Evidence-Based Program Reimbursement Strategies

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Opportunities for EB Programs

• A critical first step in seeking contracts is to first assess your market (Market Analysis)
• Complete a SWOT Analysis
• Gap Analysis
• Develop a Strategic Plan
• Opportunities can be found through program alignment with customer goals and consumer needs
• Know the current reimbursement requirements and study your market
Medicare Coverage

- **DSMT**
  - Diabetes Self-Management Training
  - Lifetime Benefit
  - Annual Refresher Training is covered
- **MNT**
  - Medical Nutrition Therapy
  - 3 Hour Benefit
  - Annual Refresher Training is covered
- **HBAI**
  - Health Behavior and Assessment Intervention
  - Goals of this closely align with CDSMP
Market Analysis Tools

- Medicare Enrollment in your market
- Medicare Advantage Penetration
- Medicare Advantage Plan Enrollment
- HEDIS Performance for MCOs
- Have detailed knowledge of the performance of providers in your market on key quality metrics
Web Resources

• ACL Medicare Advantage Penetration Tip Sheet
  – http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/MA_Penetration_Analysis_Tip_Sheet_Final.pdf

• ACL Medicare Advantage Enrollment Tip Sheet

• ACL Medical Loss Ratio Tip Sheet
  – http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/Medical_Loss_Ratio_Tip_Sheet_Final.pdf
Customer Vs Consumer

- The new marketplace requires that you meet the needs of the customer and the consumer
- **Customer** – Managed Care Plan
- **Consumer** – Beneficiary receiving services paid for by the Managed Care Plan
What does the Consumer Need

• Consumer requires services that meet medical necessity to support the consumer in meeting their healthcare goals in the least restrictive environment as possible.
What does the Customer need?

- Data
- Data
- More Data
- MCOs have performance-based contracts
- Financial and Quality Risks
- How do you contribute to improving quality and reducing financial risk?
  - If you are not, why should they contract with you?
Shift Towards Value-Based Care

- ACA continues to have sweeping changes to the healthcare delivery system across the country
- The Patient Protection and Affordable Care Act
  - Health Reform. Commonly called the Affordable Care Act or ACA
  - Signed into law by President Obama on March 23, 2010
  - On June 28, 2012, the Supreme Court rendered a final decision to uphold the law
The Evolution of the System

• Disease Management is quickly becoming an essential component of population health and value-based contracting
• Your ability to improve health outcomes while lowering costs must be the cornerstone of your value proposition
• Medicare Advantage now required to cover ALL services covered by Original Medicare (Part A & Part B)
Opportunities for EB Programs created by ACA

- Value-Based Purchasing
- Medicare Advantage Reward-Incentive Programs
- Medical Loss Ratio Requirements

- Aligning your program to these initiatives will increase contracting opportunities
Value-Based Purchasing

- ACOs
- Physician Payment Modifier
- Hospital Readmissions
- Hospital Acquired Conditions
- Hospital Value-Based Payment Modifier
ACO Measures

• **Accountable Care Organizations**
  – An association of hospitals, providers and insurers in which all parties assume accountability for the quality of patient care, and how money is spent as it pertains to a population.
  – ACOs are eligible for a percentage of the savings that they create – Shared Savings
    • Pioneer ACO – Up to 75%
    • MSSP ACOs – 50 – 60%
    • (Must achieve quality and cost containment goals)
Applicable ACO Quality Measures

- Falls: Screening and intervening for Fall Risk
- Medication Reconciliation
- Prevention: Influenza and Pneumococcal vaccination
- Weight screening and follow-up
- Diabetes: HbA1c control, B/P control, ASA compliance
- CVD: Medication compliance (ACE, Beta, Statin, ASA)
- All-Cause Readmissions
ACO Opportunity

- Ability of your EB-Program to assist the ACO in meeting their mandated quality metrics
- Requires data collection, reporting, and quality assurance
- ACO providers are graded on the documentation that is found in their E.H.R.
- Must have the ability to support transfer of pertinent information into physician/hospital E.H.R.
Why wouldn’t the ACO pay for my services?

- If the ACO reports a preference not to pay for services it may be tied to how they are compensated.
- Understanding their compensation model is key
- Often, their preference would be to assist the CBO in getting compensation from third-party payer (Medicare)
  - Become the preferred provider of preventive health programs for the entire ACO population
  - Your ability to bill Medicare directly or through partnership will facilitate the referral process
  - Same strategy may work for Medicare Advantage plans
• MCOs, ACOs, Health Systems, and Physicians that require improved outcomes will buy or build the infrastructure to improve outcomes

• Your value proposition must present an option where the value of the services and the COSTS provide a ROI that is much greater than the cost to build

• CMS ACO Information Website
  – http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html
Value-Based Purchasing Opportunities

- Disease self-management programs that can address the cost of care, reduce readmissions, and improve outcomes address key issues facing the healthcare system
  - Improve Physician Value-based purchasing
  - Reduce Readmissions Penalties
  - Improve Hospital Value-based purchasing
  - Health Systems and industry will create programs to address this problem if good options are not presented
    - ROI must be clearly defined and measured
ACA Mandate

• Hospital Readmissions Reduction Program
• Section 3025 of the Affordable Care Act
  – Requires CMS to reduce payments to hospitals with excess readmissions (up to 3% of total Medicare payments)
  – 2015 rules add additional conditions to the program
    • COPD
    • Total Hip and Knee
    • CHF
    • Acute MI
    • Pneumonia
• FY 2015 – 2,610 hospitals received a readmissions penalty
Hospital-Acquired Condition (HAC) Reduction Program

• Section 3008 of the Affordable Care Act established the HAC Reduction Program
  – HACs are a group of reasonably preventable conditions that patients have upon admission to a hospital, but developed during the hospital stay.

• Performance is based on a hospital’s total HAC score, which ranges from 1 to 10
  – The higher the score, the worse the hospital performed
  – Beginning 2015, hospitals with the highest score receive a 1% penalty for all Medicare payments
2015 Physician Value-Based Payment Modifier

- Beginning calendar year 2015, Medicare will apply the Value Modifier to physician payments for physicians in groups of 100 or more
- Applies to groups of 10 or more in 2016
- Applies to all physician practices, regardless of size, in 2017
  - Physicians in an Medicare ACO are Exempt
Hospital Value-Based Purchasing

- Section 3001(a) of the Affordable Care Act
- The program attaches value-based purchasing to the payment system
  - Participating hospitals are paid for inpatient care based on the quality of care, not just quantity of the services they provide
    - 2015 VBP application is 1.5%
  - The program uses the Hospital Inpatient Quality Reporting (IQR) Program authorized by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 – President George W. Bush
Cumulative Penalties for hospital performance

- **Readmissions Reduction Program**
  - 3%
- **Hospital Acquired Conditions**
  - 1%
- **Value-Based Purchasing**
  - 1.5%
- **Grand Total at-risk**
  - 5.5%
What about Medicare Advantage

• Sometimes called “Part C” or “MA Plans”
• Medicare Advantage plans are required to cover all Medicare Part A and Part B benefits
• When a beneficiary elects Medicare Part C (Medicare Advantage) they have elected to have their Part A and Part B benefits managed by a Private Health Insurance plan that is approved by CMS to operate a Medicare Advantage Plan
• Medicare Advantage plans received a risk-adjusted capitated payment amount
• Each Medicare Advantage plan must manage their “Risk” and cover the cost of all Medicare Part A and Part B benefits required by their enrollees with the premium payments collected
Medicare Advantage Enrollment

- Kaiser Family Foundation Report (Jan, 2015)
- In 2014, the majority of the 54 million people on Medicare are in the traditional Medicare program
- 30% are enrolled in a Medicare Advantage Plan
  - There has been consistent growth in the number of Medicare Advantage enrollees over time
  - Enrollment in Medicare Advantage varies by State and Markets within a State
MA Plan Enrollment Map

Exhibit 2
Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014

National Average, 2014 = 30%

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2014.

Exhibit 2. Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014
The Affordable Care Act requires all health insurance plans to submit data on their revenue and expenses.

- Applies to all commercial insurance plans
- Beginning January 1, 2014, applies to all Medicare Advantage (Part C) and Part D plans
MLR Calculation

• MLR Equation Numerator: includes all health care paid claims along with any quality improvement activity (QIA).

\[
\frac{\text{Claims + QIA}}{\text{Premium} - \text{Allowable Deductions}} = \text{MLR}
\]
Quality Improvement Activities

• Can be included in the MLR Numerator calculation
• Must stand up to audit
• Designed to improve health quality
• Designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and can produce verifiable results
Quality Improvement Activities Defined

- Medication Therapy Management
- Improve health outcomes, including
  - increase likelihood of desired outcomes vs. baseline
  - reduce health disparities in specified populations
- Prevent hospital readmissions
- Improve patient safety
  - reduce medical errors
  - lower infection and mortality rates
- Increase wellness and promote health activities
- Enhance use of health care data to improve quality, transparency, and outcomes
MLR Requirements

• Commercial Plans (began January 1, 2011)
  – 80% for individual and small group plans*
  – 85% for the large group market

  * ACA defines small group plan as having 1 – 100 average total number of employees (ATNE).

• Medicare Advantage (began January 1, 2014)
  – 85% for all MA plans

• Medicare Part D (began January 1, 2014)
  – 85% for all Part D plans
Penalties for MLR Non-Compliance

• Commercial Plans
  – Must submit a pro-rated rebate to all enrollees in the amount equal to the difference between actual MLR and the required MLR per statute.

• MA’s and Part D Plans
  – Starting with the 1st year of non-compliance:
    o Must send the rebate to CMS
  – Non-compliant for three (3) consecutive years:
    o Prohibition of new enrollments
  – Non-compliant for five (5) consecutive years
    o Termination of CMS contract
Medicare Advantage Prevention and Health Improvement Incentives

- CY2015 Final Rule expands rewards and incentive program that focus on encouraging participation in activities that improve health, efficient use of health care resources and prevent injuries and/or illness

- Allows MA plans to pay a reward to participants as an incentive to participate in defined preventive health programs
MA Plan Rewards and Incentive Program example

• MA Plan identified all of their members with a diagnosis of diabetes
  – Notifies those beneficiaries that if they participate and complete a diabetes self-management training program, provided by a DSMT program in the MA network
  – MA plan authorized to pay $75 to each member that completes the DSMT class
  – MA plan still obligated to pay the network DSMT provider for providing the class, based on contracted rate
  – Incentive increases participation in EB-DSMT program
Prevention and Wellness Activities

• Prevention and Wellness activities benefits for a MA plan
  – Expenses apply to the MLR
  – Preventive health activities reduce the likelihood of high-cost disease complications that increase the MLR above the 85% threshold
  – Unpredictable disease complications can dramatically raise the MLR amount far above allowable limits
  – Plans with high MLR have reduced profitability

• Ex. MA plan with a 91% MLR increased premiums for 2015 by 40% resulting in member dis-satisfaction and member disenrollment
Medicare Risk Adjustment

• CMS risk adjusts payments made to health insurance plans
  – MA Plans
  – PACE organizations
  – Part D Plans

• Purpose of risk adjustment
  – Payment to plans based on the relative risk of the beneficiaries they enroll
  – Risk adjustment allows CMS to make appropriate payments based on differences in expected costs
Risk Adjustment detail

- Balanced Budget Act of 1997 (BBA) mandated that a risk adjustment payment methodology
  - Incorporates information on beneficiary health status
- CMS currently administers risk adjusted payments as follows
  - MA plans under Section 1853(a)(3) of ACA
  - PACE – 1894(d)(2) of ACA
  - Part D Plans – 1860(d) of ACA
Hierarchical Condition Category (HCC) Methodology

• CMS-HCC model includes both diseases and demographic factors
• Clinical diagnostic information must be gathered and submitted electronically to the MA plan in order for them to submit the data to CMS to obtain the appropriate risk adjustment
• Failure to properly document services and the need for additional services results in the plan and the provider obtaining less than they are owed
• Medicare Requirements are almost identical to most Medicare Advantage Plan Requirements
• Remember that Medicare Advantage Plans must cover all services covered by Original Medicare (Part A & Part B)
• DSMT is a covered benefit for all Medicare and Medicare Beneficiaries with a diagnosis of diabetes
Purpose of Program Accreditation

- CMS mandates that DSMT programs obtain accreditation from a CMS approved accrediting organization.
- Accreditation provides evidence that a program adheres to a minimum level of quality standards in the delivery of DSMT.
- The quality standards encompass the program structure, curriculum, and internal quality controls.
CMS Approved Accrediting Organizations

- American Diabetes Association (ADA)
- American Association of Diabetes Educators (AADE) – March 2009
- Accreditation process, for both organizations, is based upon the National Standards for Diabetes Self-Management Education (DSME)
DSMT and MNT

- **Medical Nutrition Therapy**
  - 3 Hours of MNT is a covered benefit under Medicare & Medicare Advantage
  - Diabetes
  - Chronic Kidney Disease
- MNT and DSMT can be provided to the same consumer but on different days
- Combined class would provide DSMT on days other than on days when nutrition-focused education is being provided
- Combined benefit
  - 10 Hours DSMT
  - 3 Hours MNT
  - 13 Hours total
Potential Program Gaps and National Standards

• Stanford Model DSMP does not have the following elements required to meet the National Standards
  – Advisory Group to promote quality
  – DSME Instructors to have regular continuing education and have one that is at least an RN, RD, or RPH/PharmD
  – Individual Assessment and education plan, developed by the primary qualified instructor
  – Personalized follow-up plan
  – Continuous Quality Improvement (CQI)
Path to Reimbursement

- A program must first attain accreditation
- Accreditation requires the program to demonstrate that their program provides diabetes self-management education according to the ten (10) National Standards
- Once Accreditation is achieved, the program must submit for Medicare recognition
- Programs that have accreditation and recognition are eligible to receive reimbursement from Medicare
History of DSMT Benefit

• The Centers for Medicare & Medicaid Services (CMS) provides reimbursement for DSMT
• Benefit began in 2002
• Benefit provides compensation for up to ten (10) hrs of DSMT per 12 month period
• All recognized Medicare providers can submit for reimbursement
• Medicare coverage
  – 80% Payment
  – 20% Co-insurance required
Hours of Training Covered

• Ten hours of training are covered in the first year
  – 1 hour of individual training
  – 9 hours of group training

• Lifetime benefit
  – Coverage during the 12 month period after the start of the service based on a provider order
  – Follow-up training is available to beneficiaries after the initial 10 hours

• Beneficiary must have a diagnosis of diabetes
  – Pre-diabetes or high-risk for diabetes does not meet the qualification

• Two part process to be eligible for reimbursement
  – 1) Accreditation 2) Recognition
What is Required Prior to the Start of Services?

• A physician or medical provider must certify that DSMT services are needed

• Physician or provider order is required prior to the initiation of services

• For direct CMS reimbursement, a beneficiary must have Medicare Part B benefits in order to have DSMT as a covered benefit
  – If they have Part C, you must have an agreement with the Advantage plan administrator

• Verify if the person has a supplemental insurance policy
Accreditation vs Recognition

• Only “Recognized Medicare Providers” can bill Medicare for services
  – It is imperative that you work with your Medicare partner to get accredited and then achieve recognition
• First step: Attain accreditation by an Nationally Recognized Organization – AADE, or ADA
• Second step: Attain recognition by submitting proof of accreditation, Medicare provider number, and National Provider Identifier (NPI) to CMS
DSMT Reimbursement per Patient

- **G0108** – Diabetes outpatient self-management training services, individual, per 30 minutes. Medicare national reimbursement = $53.27 (2015)
  - Medicare coverage allows for 1 hr of initial individual training so projected revenue for G0108 = 2 units/new pt or $106.54

- **G0109** – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes. Medicare national reimbursement = $14.30 (2015)
  - Medicare coverage allows for 9 hrs of initial group training so projected revenue for G0109 = 18 units/pt or $257.40
Cost of EB programs

• It is essential that a program determine the true cost of delivering their EB programs.
  – A program that is offered twice a month should not require full-time staff to support it
  – Apply personnel costs according to the percentage of each staff person’s time spent administering the program

• The program is negotiating blind if they do not know the true costs of delivering their EB program
### Sample Medicare Reimbursement Model

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<th>Program</th>
<th>Code</th>
<th>Reimbursement</th>
<th>Qty</th>
<th>Total</th>
<th>Medicare Collection</th>
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<td>G0108</td>
<td>$53.27</td>
<td>Ea/30 min (2 Units)</td>
<td>$106.54</td>
<td>80% = $85.23</td>
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<tr>
<td>DSMT (Group)</td>
<td>G0109</td>
<td>$14.30</td>
<td>Ea/30 min (18 Units)</td>
<td>$257.40</td>
<td>80% = $205.92</td>
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<tr>
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<td>$35.04</td>
<td>Ea/15 min (4 Units)</td>
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<td>100% = $140.16</td>
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<tr>
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<td><strong>$8,526.90</strong></td>
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• In 2002, six (6) CPT codes were added to the CPT coding system for Health Behavior and Assessment Intervention services.
• HBAI services are provided to address the behavioral, social, and psychosocial barriers to the self-management of one or more chronic diseases.
Purpose of HBAI Codes

• These codes are specifically intended to address any or all of the following barriers to disease self-management of a chronic physical condition:
  – Cognitive
  – Emotional
  – Social
  – Behavioral functioning
Do MA Plans Cover HBAI

• All Medicare Advantage plans are required to cover all of the services that are covered by Original Medicare – Part A and Part B. As a result, all Medicare Advantage plans are mandated to cover HBAI services. Any organization that wishes to provide reimbursable services to a Medicare Advantage plan, must first obtain a direct contract with the specific Medicare Advantage plan to provide the covered service(s).
Requires Clinical Oversight

- Medicare
  - Physician
  - Nurse Practitioner
  - Licensed Clinical Psychologist

- Medicare Advantage
  - Physician
  - Nurse Practitioner
  - Licensed Clinical Psychologist
  - Licensed Clinical Social Worker
HBAI Codes

- The list of HBAI codes includes the following:
  - 96150: Initial Health and Behavior assessment
  - 96152: Individual intervention
  - 96153: Health and Behavior intervention service provided in a group setting
What is the Value of Knowing the Market Penetration?

- If you have heavy penetration of Medicare Advantage in your area, you can use the CMS site to identify which plans have the largest market share.
- This information is obtained using the file labeled SCC_Enrollment_MA
- This information is also listed by County
- The plans with the largest market penetration should be targeted for contract negotiations.
- You should be aware the types of insurers serving your patient base when determining your negotiation strategy.
Questions

- Questions can be submitted in this open forum or by e-mail:
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