Webinar Instructions

Thank you for joining today, please wait while others sign in.

- Phone Dial in: 1-866-740-1260
- Access code: 4796665#
- Due to the large number of participants, all lines will be muted during the call.
- If you want to ask a question, please type in your question into the box.
Diabetes Self Management Training: How It Benefits Seniors and Steps to Reimbursement

Agenda

- Learn about Stanford Diabetes Self-Management Program (DSMP) and how to sustain it through Medicare reimbursement
  - Timothy P. McNeill, RN, MPH, DSMT Program Contractor, U.S. Administration on Aging

- Q&A – All
Diabetes Self-Management Program Model for Area Agencies on Aging

Timothy P. McNeill, RN, MPH
DSMT Consultant
Webinar Agenda

• Consulting Initiative Overview
• DSME Program Accreditation
• National Standards for DSME
• Stanford Model and Program Accreditation
• Internal Capacity Assessment for Services
• Potential Payors for DSMT
• Medicare Market Analysis
• Interpretation of Market Analysis Data
Initiative to Expand Evidence-Based Programs

• Many Area Agencies on Aging began providing evidenced-based programs with Federal grant funding support

• Services were targeted to those with chronic disease because of the burden of disease in the County
  • According to Medicare claims data, from 2009, approximately 27% of all Medicare beneficiaries have a diagnosis of diabetes
  • Diabetes is the leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults in the United States

• Stanford Model uses trained lay leaders or CHWs to provide instruction
  • Chronic Disease Self-Management Program (CDMSP)
  • Diabetes Self-Management Program (DSMP)
In order to support sites with obtaining sustainability, I help develop a business model that could be used to support their DSMP programs and by accessing Medicare DSMT benefit.

This has been part of a larger four year initiative to develop the infrastructure to develop sustainable models of DSMP delivery.

- Toolkit produced outlining the steps to pursuing DSMT reimbursement
- Business model incorporates MNT
- Technical Assistance provided to progressive sites to develop a model for achieving reimbursement
- Expand the model to other sites seeking sustainability
Initiative Status

• Working with six (6) programs in the United States that are pursuing establishing a sustainable business model for DSMT services
  • Services include: developing the required infrastructure for accreditation, assist with billing Medicare, developing a business model, and project break-even and potential surplus

• Two (2) sites have achieved full accreditation by the American Association of Diabetes Educators (AADE)
  • One site has begun providing services, based on the model and have submitted to their fiscal intermediary for reimbursement for services
DSMT Accreditation

• What is the purpose of program Accreditation
• Who is approved to accredit DSMT programs
• Is the Stanford Model a type of program that can receive accreditation?
• Complimentary services and program fidelity
• Is my program ready to submit for accreditation?
• What should we do to prepare?
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)
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
  - CQI
Program Fidelity

• It is important to maintain program fidelity
• The Stanford model is an evidence-based program therefore program fidelity is required to achieve the desired results
• Supplemental items that occur outside of the formal Stanford program delivery are required to meet the National Standards while maintaining fidelity
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
• 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
  • Accreditation
  • Recognition
• Medicare diagnosis of diabetes defined:
  • A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions
  • A two-hour post glucose challenge greater than or equal to 200 mg/dl on two different occasions
  • Random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes
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

• Person must have Medicare Part B benefits in order to have DSMT as a covered benefit

• Verify if the person has a supplemental insurance policy
DSMT Providers

• The Stanford Model does not employ licensed personnel as part of the program.
  • I had to establish the process of incorporating licensed personnel, while maintaining program fidelity

• In order to get a program accredited there must be direct supervision of the instruction by a licensed instructor.
  • Registered Dietician
  • Registered Nurse
  • Registered Pharmacist
Accreditation vs Recognition

• Only “Recognized Programs” can bill Medicare for services

• 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
• Medicare Part B covers 10 hours of initial training

• Training must be within in a 12-month period from the initiation of DSMT services

• Services are generally provided with 1 hour of one-on-one instruction followed by up to 9 hours of group training
  • CMS regulations state that a group can include 2 to 20 persons. However, recall that Stanford requires a maximum limit of 15
  • Groups can be comprised of Medicare Part B beneficiaries as well as non-Medicare beneficiaries
• G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes. Medicare national reimbursement = $54.70 (2011)
  • Medicare coverage allows for 1 hr of initial individual training so projected revenue for G0108 = 2 units/new pt or $109.40

• G0109 – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes. Medicare national reimbursement = $18.69 (2011)
  • Medicare coverage allows for 9 hrs of initial group training so projected revenue for G0109 = 18 units/pt or $336.42
• Programs that incorporate MNT into DSMT can increase program revenue

• Always approach your plan with the worst case example in mind

• Think Murphy’s Law when preparing your budget

• Preparing for the worst ensures that your program will survive turbulent times

• Begin with your program expenses and then move to your income projections.
Program Budget

• Begin with expenses because revenue is fixed per client. Only expenses and participant volume can be adjusted.

• Expenses should be tied to productivity. Staff must have productivity projections that must be reported regularly.

• A drop in productivity is a reason to be concerned.

• Remember: Revenue = [Volume x Reimbursement] – expenses.

• If volume decreases, your profitability drops.

• If expenses increase, your profitability drops.
• Apply personnel based on a FTE
  • A way to measure a worker’s involvement in a project. An FTE of 1.0 means that the person is full time.
  • 0.5 FTE = half-time
  • 0.25 FTE = Quarter-time
  • FTE method allows you to allocate a worker’s time to multiple projects or profit centers
  • An Example is a 0.25 PQI will have only 0.25 of their monthly salary billed to the DSMT program. The remainder of their salary should be billed to another profit center
• Break-even point is the point at which costs or expenses and revenue are equal
• Usually calculated on an annual basis
• Income and expenses are spread over an annual basis to calculate break even
• In order to break even, you should increase income or reduce expenses
• Plan for attrition
• Plan for the number of completers that are required to cover your annual expenses.
Break Even Questions

• Can you realistically meet the break-even numbers?
• If your projected volume of clients is not realistic, what can you do to increase the volume?
• What can you do to decrease the expenses?
• What is your current demand for services?
• You should have an agreement with your Medicare provider partner about acceptable expenses.
• Profit is split after all expenses are covered.
• Ensure that your share of profit covers program expenses plus some margin that can be used for program development.
Disease Self-Management in the market

- More and more payors are realizing that disease management is essential to lowering costs.

- Many national insurers such as United Healthcare, Centene Corp (Medicaid MCO), Amerigroup (Medicaid MCO) and others are beginning to provide financial incentives to the patient for completing disease self-management education.

- Medicare will be doing a demonstration to provide an incentive to beneficiaries that complete disease self-management education.

- PCMHs and ACOs – focus is on lowering costs for persons with chronic disease. Disease self-management is required.
Opportunity

- Identify the types of insurers in your area
- Investigate to see if they cover disease self-management education and training
- Review how to become a provider under this plan
- Accreditation provides leverage in the negotiation
- You should know how to price your service before beginning negotiations
Patient Centered Medical Homes

• A PCMH is a team-based model of care led by a physician who provide continuous coordinated care through all stages of a patient’s lifetime

• PCMH Accrediting organizations

• Multiple financial incentives to primary care physicians to become accredited as a PCMH

• Many States and insurers are enacting policies to provide enhanced reimbursement to physicians that become certified as a PCMH

• Key standard to become a PCMH – Practice must provide programs to actively support patient self-management
What is Your Market Reach

• You must know your market to negotiate successfully

• Many healthcare institutions assess their financial status based on the percentage of Medicare patients they serve annually

• You should know the universe of Medicare Patients in your area, types of products they utilize, and the number that you serve
Insurance Products Serving Medicare Beneficiaries

- **Traditional Medicare**
  - Standard fee-for-service Medicare. Often referred to as Part A and Part B. Beneficiaries must elect Part B. It is not automatically provided with Part A.

- **Medicare Advantage**
  - Part C. Private managed care Medicare Insurance product. Provided by private insurers that are contracted with CMS

- **Medicare Part D**
  - Pharmacy benefit insurance

- **Medigap Policy**
  - Supplemental insurance product to cover the co-insurance for traditional fee-for-service Medicare
Medicare Market Analysis

- Medicare enrollment data is available from CMS at the County level
- You should know the market penetration in your area
- CMS provides monthly enrollment and Medicare Advantage market penetration on the CMS website
At the following link, CMS provides monthly Medicare enrollment data:

https://www.cms.gov/MCRAdvPartDEnrolData/01_Overview.asp#TopOfPage

Once at this page you can make a quick assessment of the numbers in your area by reviewing the Medicare Advantage Penetration Table.

- State_County_Penetration_MA
• Information presented includes
  • Total number of Medicare beneficiaries by county
  • Total number enrolled in a MA plan

• Market penetration can be analyzed using the following calculation

\[
\frac{\text{Total Number of beneficiaries}}{\text{MA Enrollees}} \times 100
\]
Sample Market Penetration Calculation

- **Hinds County, MS (December 2010)**
  - Total Number of Medicare Beneficiaries = 35,090
  - Total Number enrolled in a MA Plan = 6,993
  - Market Penetration of MA = \( \frac{6,993}{35,090} \times 100 = 19.93\% \)

- **San Diego County (December 2010)**
  - Total Number of Medicare Beneficiaries = 394,067
  - Total Number enrolled in a MA Plan = 158,726
  - Market Penetration of MA = \( \frac{158,726}{394,067} \times 100 = 40.27\% \)
What is the Value of Knowing the Market Penetration?

- If you are running a program in Hinds County, MS almost 80% of the Medicare Population is straight Fee-For-Service.
- In San Diego, 40% are enrolled in a Medicare Advantage plan.
- Providing DSMT to a Medicare fee-for-service beneficiary an accredited program bills CMS.
- When you service a Medicare Advantage beneficiary, you must negotiate separately with the Private Insurance plan – before providing services.
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 identity 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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