Sustainability in a Changing Healthcare Landscape

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1. Sustainability
2. Medicare Fee-For Service
3. Managed Care
4. Management Services Organizations

1. Sustainability

- Preventive health and wellness programs can obtain reimbursement from Medicare and other payers for providing services to eligible beneficiaries
- Services must be provided in a manner that adheres to the regulatory requirements applicable to medical services

Sources of Reimbursement

- Medicare Fee-for-Service
- Medicaid Managed Care Organization (MCO)
- Medicare Advantage Plan (Part C)
- Alternative Benefit Plan (ABP)

Sources of Consumers

- Health Plans
- Accountable Care Organizations (ACOs)
- Health Systems
- Patient Centered Medical Homes
- Internal Programs
- Employers

Customer vs. Beneficiary

- Customer: The **payer for** the services provided
- Beneficiary: The **recipient of** the services provided

- In Healthcare, the customer (payer) and the beneficiary (recipient) are often separate and distinct

Service Model

- Beneficiary consent for services
- Assessment of educational needs
- Development of an education plan and setting of education goals
- Implementation of the plan
- Evaluation of the effectiveness of the intervention to achieve planned goals
- Documentation to meet HIPAA standards

Medical Necessity

- A clinical model for preventive health and wellness programs must meet medical necessity requirements to receive reimbursement
- Medical Necessity generally requires:
  - **Provider referral for services**
  - **Clinical plan**
  - **Clinical supervision**
  - **Communication of services outcome to the referring provider**

2. Medicare Fee-for-Service

- Diabetes Self-Management Program (DSMP) and Chronic Disease Self-Management Program (CDSMP) can obtain reimbursement from Medicare
- Need a Medicare provider and have the appropriate infrastructure in place to obtain reimbursement
  - Community-Based Organizations (CBOs) can obtain a Medicare number or partner with a Medicare provider to bill for services

Medicare Provider Enrollment

- Medicare covers DSMT (Diabetes Self-Management Training) services
- A provider that only provides DSMT services is not eligible to become a Medicare provider
- A provider must deliver a primary service other than DSMT to be eligible to become a Medicare provider

Medicare Enrollment (cont.)

- A provider can provide Medical Nutrition Therapy as an eligible **primary** service
- DSMT will be the **secondary** service
- Must submit a 855 form
- Once you become a Medicare provider, you are subject to Medicare audits and reviews

855B Overview

- Medicare enrollment form
- Primary application form for an organization submitting to become a Medicare provider is the 855B
- 855B required to register the organization to provide services
- Organization type for purposes of enrollment
  - **Clinic / Group Practice**
    - Group Practice: an organization that employs professionals to provide Part B services

DSMT/MNT Example

- Anywhere, USA AAA has a registered dietitian on staff
- Registered dietitian provides MNT and supervises the DSMT classes
- Anywhere, USA AAA files for a Medicare provider number as an organization, using the 855B
- The AAA will submit as a group practice providing MNT services (primary service) and DSMT services (secondary service)

Medicare 855B Link

- The following link takes you to the 855B enrollment application:
  - **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855b.pdf**

MAC Contractors

- All Medicare enrollment forms are processed by the State MAC contractor
- MAC – Medicare Administrative Contractor
- You can find your MAC contractor at the following link:
  - **http://www.cms.gov/medicare-coverage-database/indexes/contacts-part-b-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAA&**

855B Basics

- Type of Supplier: Clinic/Group Practice
- Must have a provider – can be a RD
- Business information
- POC
- Comments section (for example):
  - **“As an organization, we will provide medical nutrition therapy as our primary Medicare Part B services to Medicare Beneficiaries. We will have a primary location and multiple satellite locations where we will provide individual and group nutrition education throughout our community.”**

Other Required Forms

- CMS Form 588:
  - **Establishes authorization for electronic funds transfer (EFT)**
- CMS Form 855i:
  - **Registers the provider or dietitian with Medicare as a provider**
- CMS Form 855R:
  - **Authorizes CMS to pay the organization for professional services rendered by the provider or registered dietitian**

Other Form Links

- 588
  - **http://www.cms.gov/apps/files/aco/cms588.pdf**
- 855i
  - **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf**
- 855R
  - **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855r.pdf**

3. Managed Care

Important to understand the market forces for managed care:

- Medical Loss Ratio
- PMPM (Per Member Per Month) Premium Payments
- NCQA Credentialing Standards

Medical Loss Ratio (MLR)

- 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).

$$\frac{\textbf{Claims + QIA}}{\textbf{Premium – Allowable Deductions}} = \textbf{MLR}$$

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:
    - Must send the rebate to CMS
  - Non-compliant for three (3) consecutive years:
    - Prohibition of new enrollments
  - Non-compliant for five (5) consecutive years
    - Termination of CMS contract

NCQA Credentialing

- The **N**ational **C**ommittee for **Q**uality **A**ssurance
- Most MCOs require all contract providers to meet NCQA credentialing standards
- Credentialing confirms that all eligible providers:
  - have current licenses,
  - are eligible to provide services, and
  - have no suspensions

Can CBOs obtain NCQA Credentialing? YES!

- A CBO **can** successfully meet the NCQA credentialing standards
- Requirements similar to the Medicare provider enrollment process
  - Must have a licensed person who provides clinical supervision of services
  - Must submit organizational structure and licensed personnel for credentialing

Contract Models

- Individual CBOs or Groups of CBOs can work together to provide services to Managed Care Organizations (MCOs) and Medicare
- Infrastructure must be able to provide:
  - **Health IT, HL7, CCD**
  - **Adherence to medical billing and coding requirements**
  - **HIPAA compliant data storage**
  - **Quality Assurance and Quality Imp.**

4. Management Services Organizations (MSOs)

Independent organizations contracted with multiple CBOs to provide infrastructure services required for successful delivery of healthcare services to MCOs:

- **Quality Assurance**
- **MCO reporting on quality**
- **Health IT**
- **Contract compliance**

MSO Advantages

Advantages to creating an MSO:

- Pooling of resources (shared staffing, billing, HealthIT)
- Standard clinical guidelines and care standards leading to improved services to beneficiaries
- Limits risk for each individual organization
- Creates an entity that can accept risk-bearing contracts
- Can provide shared governance with equal representation for all participating CBOs
- Can provide profit-sharing under shared savings contract models

MSO Shared Governance

- MSO can provide shared governance that is representative of the CBOs it supports
- MSO can have a board of directors that defines the operations of the MSO
- Each CBO can have a seat on the board with an equal vote in directing the operations of the MSO
- Non-profit and public representation

MSO Example: Anywhere, USA

- Anywhere, USA wanted to create an MSO that would enable regional contracting with MCOs and provide various services to the member CBOs
- They wanted the MSO to enter into risk-bearing contracts with MCOs and distribute shared savings to the CBO members
- The MSO would be supported by contract fees paid by the MCOs

MSO Sample Structure

- The Anywhere, USA MSO assumed the following structure:
  - The CBOs created a new independent Non-Profit
  - The Non-Profit became the single, corporate owner of a new LLC
  - The LLC operates as the MSO
  - The CBOs have representation on the Non-Profit board and direct operations of the LLC

Non-Profit MSO Example

- In the Anywhere, USA example, the MSO was NOT a non-profit
- A non-profit structure would not work for this example because they were going to enter shared savings contracts
  - Shared savings, paid by the MSO, would not be possible, if the MSO is a non-profit because non-profit regulations prohibit distribution of proceeds to board members (the CBOs)

Legal Considerations

- Consult an attorney to determine the best structure for **your** organization
- If you choose a model using a lead contract entity, this entity must assume the risk for services provided by the subcontract CBOs.
- The primary risk is always borne by the lead contract entity, even if it is only a fiscal agent

Questions and Resources

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- This Powerpoint will be posted soon

- Tip sheet on how to obtain a Medicare Provider Number on NCOA website

http://www.ncoa.org/improve-health/center-for-healthy-aging/chronic-disease/diabetes-self-management.html