

Maintaining 340B Qualification Through Population Eligibility Management

FEATURE: ROBERT F. GRICIUS AND DOUGLAS WONG

BY CAREFULLY TRACKING THE MAKEUP OF ITS PATIENT BASE, A HOSPITAL CAN ENSURE ITS CONTINUED QUALIFICATION FOR THE 340B PROGRAM, THEREBY OPTIMIZING ITS PAYMENT RATES.

It is one thing for a hospital or health system to qualify initially for the Medicare 340B Drug Pricing Program; it is an entirely different matter to continue to stay qualified every year, considering all the moving parts there are today in healthcare utilization. Just a few examples of factors that may have a bearing on an organization's ability to continue participating in the program include:

- The Two-Midnight Rule (it may apply only to Medicare now, but that is where industry standards are set)
- Bundled pricing with a strong sub-acute care focus
- Aggressive utilization management by Medicare Advantage payers
- Larger growth in Medicare Advantage than among Medicare fee-for-service members
- Growth in the overall number of Medicare members (and days) due to the aging of the baby boom, which increases the denominator in Medicare/Supplemental Security Income (SSI) fraction

To effectively manage continuing eligibility in the 340B program, participating hospitals and health systems must track the eligibility and help secure the participation, where appropriate, of all the relevant major government and government subsidized population groups they serve. These groups are the major drivers for the qualifying threshold metric. One group consists specifically of patients enrolled in Medicare Parts A and C who are receiving Title XVI Federal payments (SSI) and are not institutionalized. Another is made up of Medicare patients and the "near Medicare" patients who need assistance navigating the 23-page SSI application administered by the Social Security Administration (SSA), which has an 80 percent initial denial rate.

These two major population groups each require a different management model.

Managing the SSI Ratio

A reduction in the SSI Ratio published by the Centers for Medicare & Medicaid Services (CMS) is the single most-prevalent reason hospitals fall out of the 340B program. By managing their SSI Ratio, hospitals and health systems can gain a meaningful level of control over, and visibility into, this key metric, which even today remains fundamentally a black box. The process consists of four major steps.

Identification of the Medicare SSI members. The first step in addressing the eligibility of the SSI members in Medicare Parts A and C is obtaining the Medicare data file that contains all the Medicare admissions per hospital fiscal year with various flags. This is the only file available from CMS that lists the admissions and days that constitute the numerator of the SSI fraction.

The chart on the next page covers more than seven hundred hospital years (i.e., more than 200 hospitals over a seven-year period, where the data does not extend over all seven years for all hospitals). Even though the data set on which it is based is at least two years old, due to the lag in reporting, it still shows that a substantial percentage of current-year SSI members can be derived from prior year data. For example, based on a 2004 base year, it shows that 11.53 percent of the members (not days) were also part of the SSI value in 2005, which dropped to 5.98 percent in 2006; similarly, 23.31 percent of the 2005 new-to-SSI members were also included in the 2006 metric.

Year-to-Year Carryover Percentage of Total SSI Patients

Specific sub-population groups also can be identified with clinical and pharmaceutical data mining that can be identified as presumptively eligible for SSI. However, unlike with Medicaid, a patient (or guarantor in the case of certain low-birth weight newborns) who has presumptive eligibility for SSI must take proactive steps, or have those steps performed by a patient representative, to secure formal eligibility.

Validation of SSI enrollment status. After a list of SSI-enrolled patients in Medicare Parts A and C has been compiled, the next step involves validation of their continued enrollment. Except for specifically requesting, with patient consent, the paid claims report (form SSA-3288) from the SSA, there is no straightforward or foolproof method for validating continued enrollment. However, it is possible to provide a level of corroboration based on correlation analysis of state Medicaid program information obtained via 270/271 EDI queries, typically provided as transaction sets and/or a batch process data exchange.

Each state categorizes SSI members differently, but all states receive a monthly file from the SSA called the State Data Exchange (SDX) report, which lists all individuals in that state who are entitled to SSI or Title XVI benefits. This report does not indicate whether the patient is entitled to federal or state SSI payments or to Medicare Part A or Part C benefits, but the Medicare status can be verified independently through the Medicare EDI or the common working file.

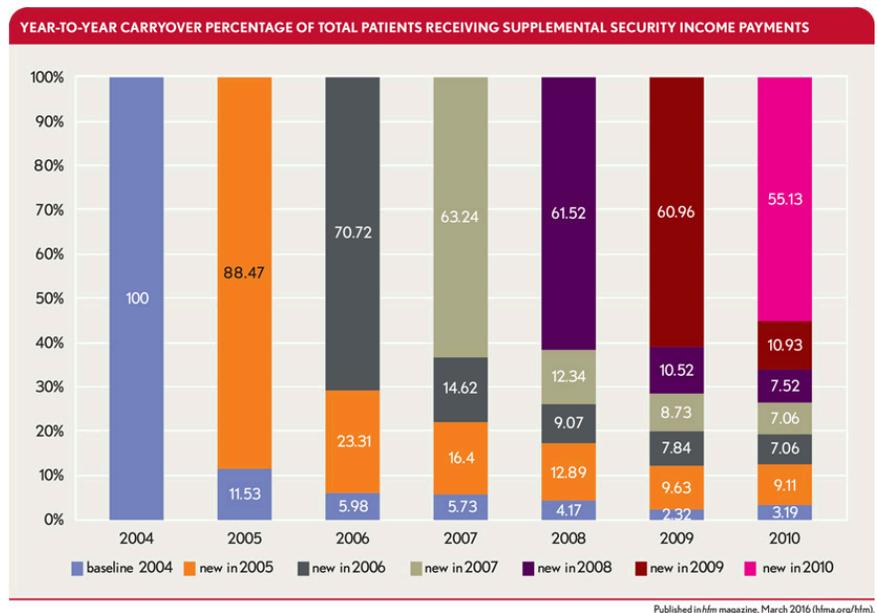
Concurrent tracking of dual-eligible SSI ratio trends. Once it is determined which state-level Medicaid aid categories and program codes are fully or partially (in conjunction with other demographic and clinical/pharmaceutical metrics) indicative of SSI entitlement, the next step is concurrent tracking of trends in this metric. This tracking can be performed monthly or quarterly, depending on how close the provider is to the 340B threshold. In the case of a newly eligible 340B hospital, providing monthly updates of an internally generated SSI ratio projection should head off a surprise later in the year, or in later years, if the trend were significantly negative. Quarterly updating would be sufficient for hospitals that are within plus or minus two percent of the qualifying level.

These periodic updates are driven by regular submission of state-level eligibility queries (in conjunction with other demographic and clinical/pharmaceutical metrics), which allows for the timely identification and tracking of changes or losses of eligibility for SSI members based on all data compiled including but not limited to updated data from the state.

Predictive analysis of potential SSI enrollees. The exhibit above illustrates the fact that there must be an ongoing replacement process to identify and enroll new Medicare Part A and C patients to receive SSI payments because it takes only a few years for the rollover effect year over year to become insignificant. The data in the exhibit indicate there was only one year (2006) when SSI patients from the prior year constituted more than 20 percent of the members; in most years, the value is roughly 10 percent. There are many reasons this metric is so low, but common reasons include member relocation, institutionalization and death.

The specific actions 340B organizations should take are to proactively identify patients in their areas enrolled in Medicare Parts A and C who are mostly dual-eligible and could qualify for SSI payments but do not now receive them, and to assist them with completion of the 23-page SSI application, which patients must complete to qualify for their initial SSI enrollment.

One way to identify these patients is to develop a predictive model using a continuously updated learning algorithm that assigns a probability for SSI qualification at the person level. This model is based on combinations of clinical, demographic, procedural,



Published in hf/m magazine, March 2016 (hfma.org/hfm).

pharmaceutical, and other available data. Ultimately, one must choose and balance threshold values with true and false positive rates to arrive at the proper decision regarding which parameters are acceptable (see the exhibit below).

Predictive Model Evaluation for SSI Qualification

There are two critical points to keep in mind regarding timing and fees when considering this strategy. First, this is a long-term approach; enrolling the right patients into the SSI program is itself a six- to 18-month process, with certain well-defined exceptions, so it will be at least two years before the results of this program will be seen in the CMS published metrics.

Second, if the provider organization engages a vendor to manage this SSI enrollment process, it is highly preferable that the vendor be registered as an authorized representative of each patient with the SSA. This registration will allow the fees to be collected from the patient from the retroactive award up to a maximum of 25 percent of the SSI payment. This arrangement also precludes a situation where the vendor charges the hospital for an enrollment that results in no value because the enrollee either does not require any future inpatient utilization or moves to another geographic location.

PREDICTIVE MODEL EVALUATION FOR SSI QUALIFICATION			
	Threshold = 0.5	Threshold = 0.75	Threshold = 0.9
True Positive Rate (TP/P)	93.2%	80.4%	44.2%
False Positive Rate (FP/N)	17.0%	1.3%	0.4%
Precision (TP/(TP+FP))	28.3%	82.2%	88.5%
Accuracy (TP+TN)/(P+N)	83.7%	97.5%	95.9%

Note: P = positive; N = negative; TP = true positive; FP = false positive.

This chart shows three options available to hospitals, demonstrating the trade-offs among different thresholds (50/70/90 percent), true versus false positive results, and overall accuracy of each choice.

Published in *hfm* magazine, March 2016 (hfm.org/hfm).

Managing Medicaid Members

The Medicaid expansion provision of the Affordable Care Act (ACA) has resulted in stunning increases in the Medicaid population. In the first quarter of 2015, for example, the average increase for expansion states was 21 percent; at the extreme end of the scale, Kentucky had an increase of 88 percent (see “About 340B and the Medicaid Expansion,” January 2016 *hfm*). Although there are hospitals that will be eligible for 340B simply as a result of Medicaid expansion, even hospitals in non-expansion states are seeing increases (e.g., Virginia, up two percent).

Medicaid expansion alone will allow some hospitals to qualify for 340B, but it will not be enough in all circumstances. Similar to SSI members, aggressive tracking of the eligibility of this unique population, with an eye toward helping non-enrolled patients who qualify for Medicaid to enroll in the program, will be crucial for a hospital or health system to retain 340B program eligibility and increase allowable Title XIX days. Like the approach to managing the SSI Ratio, this effort will require four major steps.

Construction of a hospital-wide or system-wide inpatient and outpatient Medicaid member database. Tracking outpatient Medicaid members as well as inpatient members is helpful in optimizing this metric because of the high prevalence of aliases in the Medicaid population.

Aliases in the population tend to proliferate because hospital Medicaid patients often provide different demographic information at different entry points to a hospital or health system, sometimes intentionally and sometimes not. A patient whose full name is Liza Smith-Jones, for example, could have a number of aliases not only in the provider’s system, but also in the state’s Medicaid Management Information Systems (MMIS)—including Liza Smith, Liza Jones, Elizabeth Smith-Jones, Elizabeth Smith, and Elizabeth Jones.

In essence, there is a primary name and, in this case, five aliases for the same person. An organization trying to match this person on name alone, name/date of birth (DOB), or name/Social Security number (SSN) must address the question of which of the six possible name spellings it should submit to all the states to allow for exchange of eligibility queries. The answer, at least for the initial submission, is all of them, because there’s no way of knowing how this person is listed in each state’s MMIS.

Here’s where data on outpatient visits can help: If the patient was registered as Liza Jones in an outpatient visit and that name corresponds with how she is listed at the state level, sending that eligibility query would provide a match and the resultant Medicaid eligibility data. Meanwhile, our hypothetical patient may have registered later as an inpatient in one of the health system’s hospitals under the name Elizabeth Smith-Jones, which does match any listing in a state MMIS.

Fortunately, if medical record numbers are consistent in all systems for this patient, with a hospital inpatient/outpatient Medicaid eligibility database in place, the outpatient eligibility information can be applied to the inpatient admission.

It's also important to note that aliases are not limited to names. They also apply to SSNs and Medicaid recipient numbers.

Managing Changes in Medicaid Status

The Medicaid population is unique in a number of ways: Its members tend to be more transitory than any other insured population groups; they generally are less well educated; and, especially for the 13 million newly enrolled members, they are likely to be unfamiliar with annual or biannual recertification required to retain continuous eligibility.

By taking an active role, providers can assist Medicaid members in retaining the proper level of coverage to ensure adequate benefit coverage. To accomplish this goal, three different possible circumstances must be identified for possible action.

Complete loss of eligibility. For various reasons, a Medicaid beneficiary can become ineligible for Medicaid coverage. It's possible, for example, for a member who had full Medicaid coverage in one month or quarter to suddenly have no non-Medicare, government-based health care in the next verification cycle. Although Medicaid members lose coverage for legitimate reasons, including increased income, a change in disability status, and other clinical or means-based rationales, they also can lose coverage for purely administrative reasons, which can be reversible and need to be identified so their MMIS records can be adjusted. Examples include process-related lapses such as failing to communicate a change of address to the local department of social services or to complete required recertification documents. Addressing such oversights on a timely basis can prevent or quickly identify and reverse any loss of coverage prior to the need for future provider services.

Downgrade of eligibility coverage. Most state MMISs provide reporting and other services for the full range of government-related healthcare coverage, including Medicaid and programs like the State Children's Health Insurance Program (S-CHIP, or Title XXI) and other healthcare programs with state or local funding. When a state moves a person from a Title XIX (Medicaid) program to a non-Medicaid program, the change usually is a highly unfavorable conversion for the provider. The value of Title XIX days far outweighs those of other non-Medicare government-sponsored or subsidized health care based on their direct use in Medicare DSH, Medicaid DSH, Medicaid Electronic health record subsidy payments, and related programs. If these negative trends can be identified on a timely basis, and if they are reversible, they should be reversed as quickly as possible before Medicaid covered services are needed.

Candidacy for possible upgrading. Just as member status downgrades should be monitored to allow for quick reversal of a negative trend, opportunities for upgrading membership coverage from non-Medicaid to Medicaid should be tracked, because such upgrades are highly favorable for a 340B program provider. The primary focus here should be on two population sub-groups: S-CHIP patients who could qualify for Medicaid, and "spend down" (or in California, "share of cost") patients whose monthly income exceeds the income level for Medicaid eligibility but who can qualify by paying medical bills to the point that their income drops enough for them to qualify, thereby essentially sharing a portion of the cost of coverage.

Spend-down Medicaid patients constitute a low-visibility population that typically receives very little attention from DSH and 340B-covered entities whose perception may be that they have little control over changing this status. Yet in the ACOs and ACO-like entities being developed, the entities still have different silos of data that may contain the medical-cost documentation necessary to enable these individuals to cross the threshold and obtain full Medicaid coverage. Integrating that silo-based information in a system-wide inpatient/outpatient Medicaid membership management subsystem will go a long way toward improving the conversion of this population to full coverage, not just for eligibility, but for payment.

Another high-visibility population group that can benefit from being converted from S-CHIP to Medicaid comprises individuals in S-CHIP programs who are presumptively eligible for Medicaid because they exhibit a precisely defined set of clinical conditions. A 340B provider organization can benefit from identifying such potentially Medicaid-eligible S-CHIP members and assisting them in applying for the superior Medicaid coverage.

Maintaining the Safety Net

The 340B program is critical to supporting the financial well-being of many U.S. hospitals, but it requires allocation of resources to maintain coverage and compliance after initial acceptance into the program. By maintaining visibility into utilization trends that can affect an organization's eligibility for this program, healthcare organizations that serve large populations of under-insured patients—and whose costs for treatment far outweigh the payments received—can continue to qualify for 340B cost reductions that will help ensure their survival as safety-net providers.

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Footnotes

- a. The metric for determining the extent to which a hospital serves a large percentage of low-income patients is explained in the authors' article "[Fast Track to 340B](#)" (*hfm*, January 2016). Eligibility is determined using the pre-ACA [Medicare disproportionate share hospital \(DSH\)](#) criteria with a threshold of 27.32 percent for DSH 340B hospitals and 22.8% for RRC/SCH DSH hospitals.
- b. The SSI metric is published by CMS annually and is equal to the Medicare fraction in the formula for 340B and pre-ACA Medicare DSH.

Publication Date: Tuesday, March 01, 2016