Reward and Incentive Programs

HOW TO STAY ON TOP OF INNOVATION AND THE REGULATORY LANDSCAPE

HCCA MANAGED CARE CONFERENCE

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AGENDA

- Evolution of Rewards and Incentives and Regulatory Landscape – Tricia
- Common and Innovative Approaches to Rewards and Incentives – Tracy
- Compliance Issues to Understand – Vince
- Q&A - All

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PART 1: Evolution of Rewards and Incentives (RI) in Managed Care

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1950s – 1970s: MAJOR EXPANSION OF GOVERNMENT AND EMPLOYER HEALTH CARE INVESTMENT

- Start of Medicare Entitlement Program
- Employers Began to Pay for Health Insurance for Employees and Expand Employee "Perks"
- Employee Assistance Programs initially created to help employees with alcohol dependence

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1980s – 2000s: FOCUS SHIFTED TO HIGH-COST PATIENTS

- Americans with Disabilities Act
- Smoking Bans and Cessation Programs, Nutrition Counseling, Stress Management
- Enactment of Medicare Part C (Medicare Advantage, MA)
- Rise of Managed Care → Disease Management and Wellness Programs

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2010s – TODAY: WELLNESS/POP HEALTH/REWARDS AND INCENTIVES EXPLODE

- 2010: Affordable Care Act – amended HIPAA to expand employer wellness programs and added new CMS Innovation Center authorities
- 2014: CMS authorizes Rewards & Incentives (RI) Programs for Medicare Advantage
- Jan. 2021: CMS codifies MA RI program guidance in regulation

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NON-MA RI/WELLNESS PROGRAMS AND GUARDRAILS

Employers

- HIPAA (amended by ACA), ADA, GINA, tax code, ERISA, privacy laws

Individual Market

- HIPAA (amended by ACA), GINA, Exchange rules (if applicable), state insurance law

Medicaid

- State contract, regulations or guidance, AKS, CMP/Bene Inducement

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MA RI/WELLNESS PROGRAMS AND REGULATORY LANDSCAPE

- Program allows **qualified individuals** (members) to voluntarily perform **target activities** (single or series) in exchange for which the plan provides **reward items**. Examples include:
  - Using plan benefits e.g., preventive benefits
  - Using plan resources in a specified manner, such as hotlines, patient portals, and similar items that facilitate health promotion
- Per MA Program Guidance, must:
  - Not a benefit; include cost in bid as an administrative cost
  - Comply with Medicare Managed Care Marketing rules
  - Be non-discriminatory:
    - Offered uniformly to any qualified individual – qualifies for coverage of benefit and any plan criteria to participate
    - Allow all (qualified) members to earn rewards with accommodations made that satisfies goal of target activity
    - Not tie activity to achieving a specific health outcome
- Part D benefit rewards only permitted for Part D Payment Modernization Model participants currently

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FORM AND VALUE OF REWARD

- Must be a direct tangible benefit to member – not a chance of winning or donation on behalf of member
- Cannot be cash, cash equivalent (items immediately convertible to cash or used "like cash" e.g., debit card), or a monetary rebate
  - Can be gift card redeemable at certain stores or chain stores, coupons, tickets to events, or points redeemable for tangible items
- No monetary cap but value must not exceed the value of the target activity itself
  - VBID and Part D Payment Modernization Model participants can expand to a level that reflects the benefit of the service, up to $600 annually.

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APPLICABILITY OF FRAUD AND ABUSE LAWS

- Anti-kickback Statute
  - Safe harbor for increased coverage, reduced cost-sharing, or reduced premium amounts (or other incentives) offered by health plans – must be offered to all enrollees
  - Dec. 2020 AKS Safe Harbor Final Rule – new patient engagement tools safe harbor, applicable to providers, restricts remuneration to limited-use gift cards and other in-kind remuneration
- Civil Monetary Penalties Law. Excluded from prohibited remuneration are incentives to promote:
  - Preventive care delivery
  - Seeking specific services - without influencing members to use particular providers
- Fallback option: nominal gift ($15/$75) exception

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PART II: Common and Innovative Approaches in Practice Today

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WHAT PROBLEMS DO RI PROGRAMS SOLVE FOR PLANS?

- Quality Improvement
  - HEDIS
  - CAHPS
  - HOS
- Member Attrition
- MLR
- Population and risk identification

Member Engagement

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ICARIO™ EXAMPLE OF RESULTS FROM RI AND ENGAGEMENT PROGRAMS

- 63% increase above the national average for annual wellness visits
- 14x higher completion rate on HRAs
- 337% increase in cancer screenings in 12 months

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TARGET ACTIVITIES

- Preventive Services
- Disease-specific care plan activities
  - Mom and Baby
  - Mental Health
  - Diabetic care
- HRA's
- Efficient Use of Healthcare Resources
  - Switching to electronic documents
  - Signing up for the plan's member portal
  - Updated contact information

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CURRENT AND FUTURE DIRECTION

- New RI safe harbors in 2020 final AKS rule
  - Patient engagements and supports
- RI for CMMI projects – VBID and Part D
  - Historically, CMS has adopted many of the CMMI models
- RI to Drive Public Health Initiatives
  - Telehealth
  - COVID-19 Vaccines
  - Engagement with mental health resources

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PART III: Compliance Issues to Understand

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STANDARD COMPLIANCE QUESTIONS TO ASK WHEN ANALYZING R&I PROGRAMS

1. What activities are being rewarded? Are the proposed activities "health related services and activities?

- Must be focused on promoting improved health, preventing injuries and illness, and or promoting the efficient use of health care resources.
- Some CMS examples of services , activities, and behaviors (not exhaustive list):
  - the utilization of a particular service(s) or preventive screening benefit(s),
  - adherence to prescribed treatment regimens,
  - attending education/self-care management lessons,
  - meeting nutritional goals, and
  - making and keeping appointments with the doctor
- The activities should be rewarded in and of themselves, rather than rewarding health outcomes or other results.
- Part D benefits, including those in a MAPD plan are prohibited (unless it is in connection with the 2021 CMS carve out for the use of a Part D tool)

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STANDARD COMPLIANCE QUESTIONS TO ASK WHEN ANALYZING R&I PROGRAMS

2. Who is being targeted and how does that selection process work?

- Pursuant to CMS guidance and federal regulations, plans are prohibited from discriminating against enrollees on the basis of "race, gender, chronic disease, institutionalization, frailty, health status or other impairments and must be designed so that all enrollees are able to earn rewards
- Plans are allowed to target by specific disease or chronic condition, but must ensure that there is no discrimination among the eligible class.
- Plans cannot discriminate against enrollees who have a good record of utilization or participation in activities/behaviors being rewarded.

3. What is the value of the reward/incentive item?

- CMS states that plans rewards/incentives must have values that are expected to elicit intended enrollee behavior, but which do not exceed the value of the health-related service or activity itself. Currently there are no limits on amounts or frequency of offerings.

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STANDARD COMPLIANCE QUESTIONS TO ASK WHEN ANALYZING R&I PROGRAMS

4. What is the reward/incentive item being offered?

- Expressly allowed by CMS:
  - Discount coupons of sufficient value to influence enrollee behaviors. Nominal discounts would be impermissible
  - A "points" or "token" program where the enrollee can shop using their accumulated credits, but the points or tokens must be able to earn tangible items.
- Expressly disallowed by CMS:
  - Games of chance. Programs that earn enrollees' entries into lotteries or drawings are prohibited.

5. **How will enrollees earn the rewards?**

- CMS requires that rewards/incentives be earned by completing an "entire service or activity".
- This means that plans can offer R&Is for individual activities or aggregated or both, but before a reward is earned the enrollee must reach the conclusion of either.

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GIFT CARD REQUIREMENTS

- CMS advises offering several options for enrollees to choose from
- CMS has deferred to the OIG for years regarding the use of gift cards.
- The Office of the Inspector General (OIG) (81 FR 88368, December 7 2016), which defines ‘‘cash equivalent’’ to be items convertible to cash (such as a check) or that can be used like cash (such as a general purpose debit card, but not a gift card that can be redeemed only at certain stores, certain store chains, or for a specific category of items like a gasoline gift card).
- Some states have laws requiring gift cards be allowed cash redemption after the balance on a card is below a certain dollar amount.
- CMS' policy is that plans may still offer gift cards as a reward in states with such laws. The original conveyance of the gift card was in a non-cash convertible form – only usable at certain locations or for certain purposes.

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MEDICARE COMMUNICATIONS & MARKETING GUIDELINES

Marketing is allowed under the following conditions:

- Must be in conjunction with marketing of plan-covered benefits.
- Plans are prohibited from offering the R&I items themselves to prospective enrollees.
- Plans can market the R&I programs, **but only without** mention of the items to be earned.
- Plan or its vendor materials will need to conform to the Medicare Communications and Marketing Guidelines (“MCMG”)

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MEDICARE COMMUNICATIONS & MARKETING GUIDELINES: COMPLIANCE IN YOUR MATERIALS

Communications vs marketing:

- Intent and content test – if both, then a material is marketing and will require upload to CMS which will require a 5-day file and use submission that may affect your timelines.
- Marketing materials may risk CMS rejection
- Communications are the more common categorization for the related materials as the majority are aimed at enrollees and intended only to administer the R&I programs.
- Language translations will be required when requested, and in contracts where the CMS 5 % threshold for non-English languages is met.
- The 1557 taglines will be a minimum requirement to ensure enrollees with limited English proficiency are able to access the programs in a meaningful way, thus avoiding unintended discrimination.

Communications Accessibility for Individuals with Disabilities/ Web Content Accessibility Guidelines:

- Sections 504 and 508 of the Rehabilitation Act of 1973 must be implemented to ensure that Medicare information is available and accessible to persons with disabilities.

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MEDICARE COMMUNICATIONS & MARKETING GUIDELINES: COMPLIANCE IN YOUR MATERIALS

Accessibility cont'd..

- Plans must have in place auxiliary aids and services to beneficiaries with disabilities that include, but are not limited to:
  - Large-print materials, Braille materials, and
  - Audio recordings for beneficiaries with low vision or blindness
  - Text messaging, email, or Relay services and text telephone (TTY) communications for beneficiaries who are hard of hearing or deaf or who have speech disabilities.
  - All documents posted in electronic form should be in a machine-readable format

- Web Content Accessibility Guidelines ("WCAG") – standards to aid in avoiding development of inaccessible content. Examples of these standards include but are not limited to:
  - A tool on your organization's home page allowing the user to customize the website (e.g., skip to content, change text size or text contrast); and
  - An accessibility link where a user can find information on how the website is accessible or what accessibility guidelines the organization follows.

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MEDICARE COMMUNICATIONS & MARKETING GUIDELINES: COMPLIANCE IN YOUR MATERIALS

Accessibility cont'd..

- HHS and CMS provide a best practices guide for Medicare Plans to serve the communications needs of their beneficiaries with disabilities. It can be found online at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/section%20504%20best%20practices%20for%20medicare%20health%20and%20drug%20programs_3.pdf
- WCAG can be accessed at: https://www.w3.org/WAI/standards-guidelines/wcag/

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TCPA – TELEPHONE CONSUMER PROTECTION ACT

- Restricts businesses in making telemarketing calls, using automatic telephone dialing systems and artificial or prerecorded voice messages (aka robocalls), and sending unsolicited faxes.
- High risk area for litigation – as vendors work to create better engagement strategies for your members, texting and IVR are often a part of the strategy.
- Key to compliance is technology used to send messages, content of the message and legally required consent.
- Important to get into the tactical weeds enough to understand if technology being used for IVR or texting meets the definition of an ATDS. The Federal Circuit courts are split. The SCOTUS will be settling the definition based on argument heard on December 8, 2020 in *Facebook v. Duguid*.
- GENERALLY:
  - you can send healthcare related text messages and IVR calls if the member has provided their cell phone/landline to their plan. This establishes the prior express consent standard required.
  - Must allow and honor immediate opt-out

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OTHER ISSUES TO KEEP IN MIND

- An RI Program is not a benefit. It must be included in the bid as a non-benefit expense but must not be entered in the Plan Benefit Package.
- The timeframe for earning and redeeming rewards and/or incentives must be within the contract year in which the RI Program has been implemented.
- Consider developing quarterly programs to manage the programs and mitigate risk of instability that may result from errors in forecasting the participation and costs etc.
- Compliance risks: violations of R&I regulatory requirements can lead to sanctions in the context of:
  - Violations of anti-discrimination regulations and statutes
  - Violations involving misleading enrollees
  - Violations of improper inducement if it involves any steering to certain plan providers

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Q&A

THANKS FOR YOUR TIME TODAY!

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