# CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents
# Phase 2--Payment Model

AQAF

# Payment Model

- Six Enhanced Care and Coordination Providers (ECCPs) entered into cooperative agreements with the Centers for Medicare & Medicaid Services (CMS) to test whether a new payment model for long-term care facilities and practitioners will
  - improve quality of care by reducing avoidable hospitalizations
  - lower combined Medicare and Medicaid spending.

# Enhanced Care and Coordination Providers (ECCPs)

- Alabama Quality Assurance Foundation - Alabama
- HealthInsight of Nevada - Nevada and Colorado
- Indiana University - Indiana
- The Curators of the University of Missouri - Missouri
- The Greater New York Hospital Foundation, Inc. - New York
- University of Pittsburgh Medical Center (UPMC) Community Provider Services - Pennsylvania

# Why Implement Payment Model?

The initial four years of the demonstration project (2012-2016) addressed preventing avoidable hospitalizations through various clinical quality models.

# Why Implement Payment Model?

HOWEVER….

the initial demonstration did NOT address the existing payment policies that may be leading to avoidable hospitalizations.

# Why Implement Payment Model?

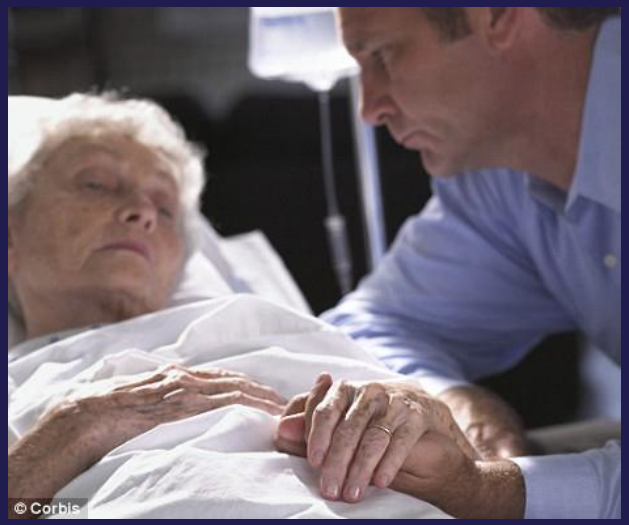
BECAUSE…

- MedPAC has reported it is financially advantageous for LTC facilities to transfer residents to a hospital*
- In decisions regarding provision of care, the focus should always be on providing the best setting for the resident/patient

*Medicare Payment Advisory Commission (MedPAC) June 2010 Report to Congress

# Why Does This Matter?

Hospitalization




At Risk for complications:

- Delirium
- Polypharmacy
- Falls
- Incontinence & Catheter Use
- Hospital acquired infections
- Immobility, deconditioning
- Pressure Ulcers
- Undernutrition

# Payment Model

Existing (Group B)
2012-2020

clinical quality model
+
new payment mechanism

Continuing LTC
N=23

New (Group A)
2016-2020

new payment mechanism

New LTC
N=23

# Payment Reforms

CMS is adding new codes to the Medicare Part B schedule specifically for this Initiative

- **Facility payment**
  - treatment of six qualifying conditions
- **Practitioner payments**
  - **#1 -** onsite treatment of six qualifying conditions
  - **#2 -** care coordination & caregiver engagement

# Principal Payment Reform Goal: Six Conditions

| CMS states that six conditions are linked to approximately 80% of potentially avoidable hospitalizations among nursing facility residents nationally | | | | | |
|---|---|---|---|---|---|
| **Pneumonia** | **Urinary tract infection** | **Congestive heart failure** | **Dehydration** | **COPD, asthma** | **Skin ulcers, cellulitis** |
| 32.8% | 14.2% | 11.6% | 10.3% | 6.5% | 4.9% |

# ECCP* Eligible Residents

- Have resided in the LTC facility for ≥101 cumulative days from the resident's admission date to that LTC
- Are enrolled in Medicare (Part A and Part B FFS) and Medicaid, or Medicare (Part A and Part B FFS) only
- Have NOT opted-out of participating in the Initiative

* Enhanced Care and Coordination Providers

# ECCP Eligible Residents *(cont'd)*

- Reside in Medicare or Medicaid certified LTC bed
- Are NOT enrolled in a Medicare Advantage plan
- Are NOT receiving Medicare through the Railroad Retirement Board
- Have NOT elected Medicare hospice benefit
- Resident's eligibility must be renewed if discharged to the community for more than 60 days.

# Facility Payment for Six Qualifying Conditions

## Purpose

- Create incentive for facility to enhance staff skills to provide higher level of service in-house

## Payment

- "Onsite Acute Care"
- Limited to 5-7 days, based on qualifying condition
- Limited to residents **not** on a covered Medicare Part A SNF stay and who meet the long stay criteria

# Facility Payment for Six Qualifying Conditions

- The six conditions have very specific, detailed qualifying criteria that could trigger the benefit
  - **Detection** of acute change of condition documented in the medical record by a physician or a nurse at the LPN level or higher
  - STOP AND WATCH tool, SBAR, free text note, structured clinical documentation are acceptable formats as long as they are part of the medical records

# Facility Payment for Six Qualifying Conditions

- Qualifying criteria that could trigger the benefit
  - MD, NP or PA must confirm qualifying diagnosis through in-person evaluation by the end of the 2nd day following the change in condition
  - ANY attending practitioner can provide confirming diagnosis for the purposes of facility payment

# Facility Payment for Six Qualifying Conditions

- If, after the nursing facility's maximum benefit period, it is suspected that the beneficiary continues to meet the qualifying criteria, a new practitioner assessment is required.

# Practitioner Payment #1 for Six Qualifying Conditions

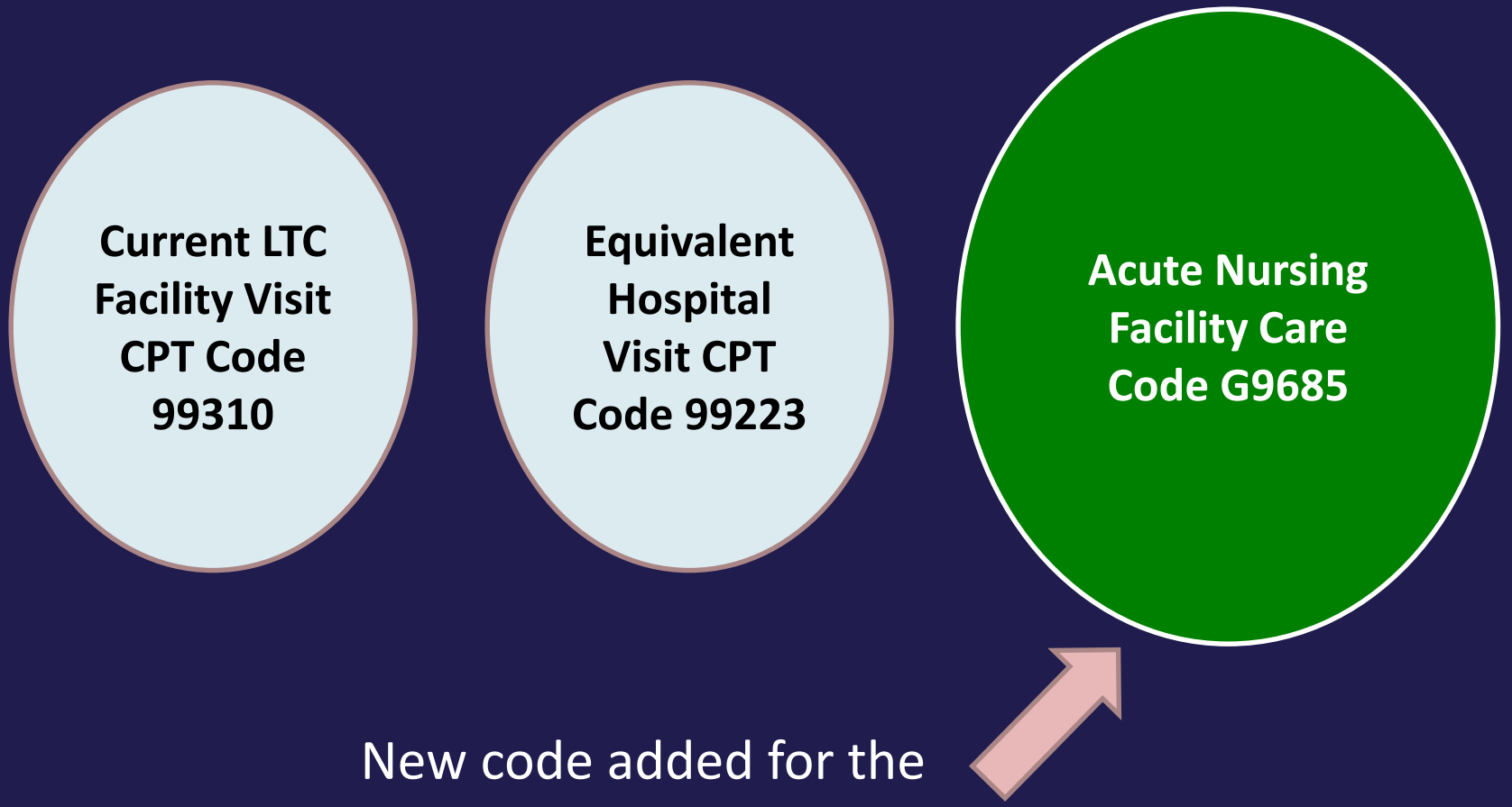
**Purpose**

- Create incentive for practitioner to conduct nursing facility resident visits to treat acute change in condition
- Equalize payment for acute change of condition visit regardless of location of service

**Payment**

- Billing Code G9685; Acute Nursing Facility Care
- Payment will be equivalent to what would be received for a comparable visit in a hospital.
- Limited to first visit in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed condition)
- NPs & PAs reimbursed at 85% of physician

# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*



## Acute NURSING FACILITY CARE

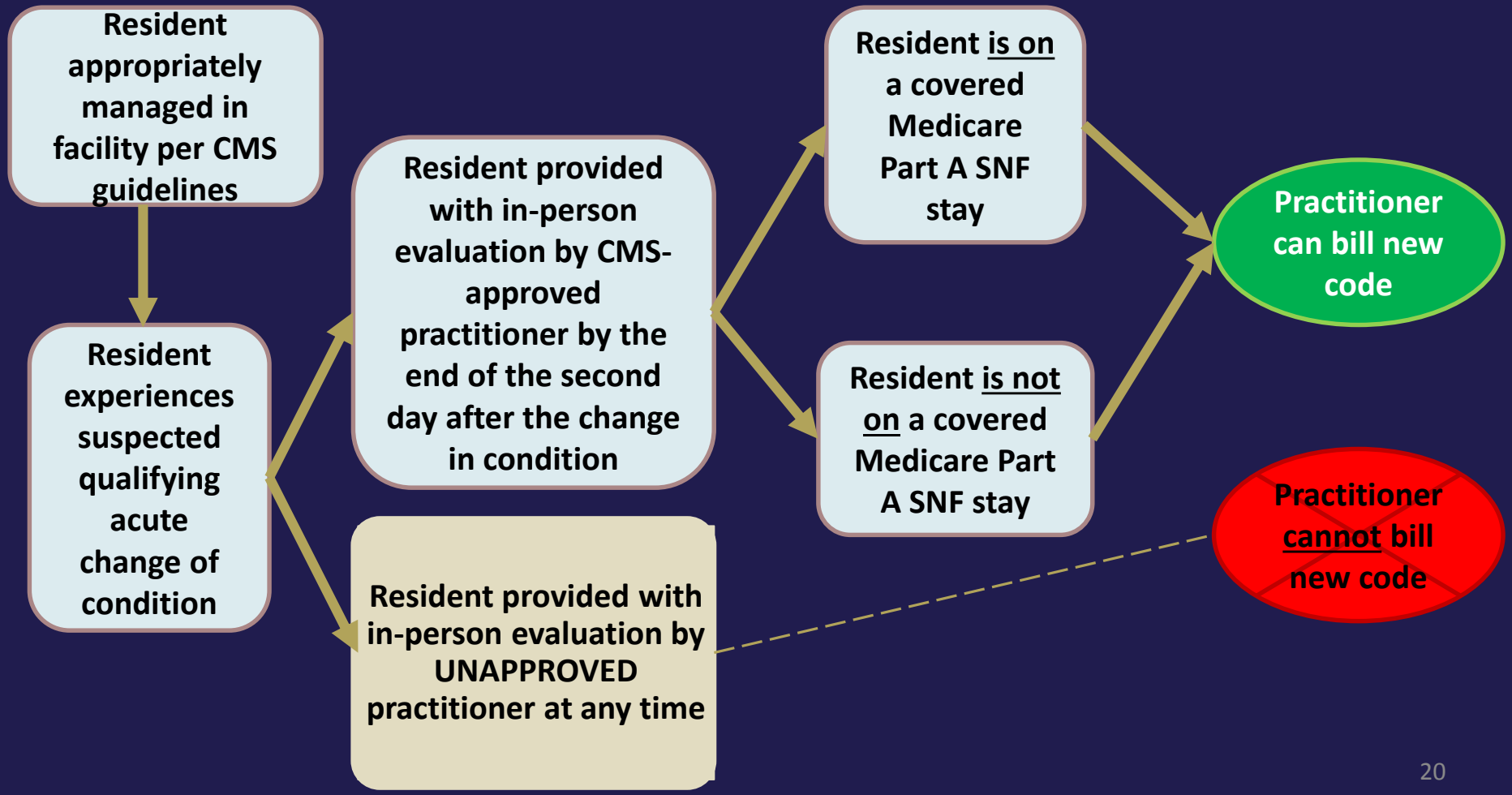
Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. (Beneficiary must meet required clinical criteria). This service is for a demonstration project.

**Key Components Required:**

- A comprehensive review of the beneficiary's history
- A comprehensive examination
- Medical decision making of moderate to high complexity.
- Counseling and/or coordinating care with nursing facility staff and other providers or suppliers consistent with the nature of the problem(s) and the beneficiary's and family's needs.

**Maximum Benefit Period: Code can be billed once per day for a single beneficiary.**

# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*



# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*

- In decisions regarding provision of care, the focus should always be on providing the best setting for the resident/patient
- Six conditions have qualifying criteria
  - MD, NP or PA must confirm qualifying diagnosis through in-person evaluation
  - Evaluation or assessment must occur by end of the 2nd day after acute change in condition
  - Evaluation documented in resident's medical record

# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*

- The new code can be billed even if the exam reveals that the resident does NOT have one of the six qualifying conditions.

# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*

- Responsibility for triggering actual payment code (G9685) is with the practitioner.
- Code may be billed only once for a single beneficiary, even if beneficiary has more than one of the six conditions.

# Practitioner Payment #1 for Six Qualifying Conditions *(cont'd)*

- Practitioner may bill the new code even if upon examination it turns out a beneficiary does not have one of the six conditions.
- CMS intends to waive any requirement for a 20% beneficiary coinsurance or payment of deductible.
- Subsequent visits would be billable at current rates using existing codes.

# Acute Care
# PNEUMONIA

**Facility service(s) for onsite acute care treatment of a nursing facility resident with pneumonia. (May only be billed once per day per beneficiary). This service is for a demonstration project.**

**Qualifying Diagnosis:**

- Chest x-ray confirmation of a new pulmonary infiltrate

**OR TWO or more of the following:**

- Fever >100° F (oral) or two degrees above baseline
- Blood Oxygen saturation level < 92% on room air or on usual O2 settings in patients with chronic oxygen requirements.
- Respiratory rate above 24 breaths/minute
- Evidence of focal pulmonary consolidation on exam, including rales, rhonchi, decreased breathe sounds, or dullness to percussion

**Symptomatic guidance:** Productive cough, increased functional decline, increase dependence in ADLS, reduced oral intake, or increased lethargy, altered mental status, dyspnea

**Treatment:** Antibiotic therapy (oral or parenteral), hydration (oral, sc, or IV), oxygen therapy, and/or bronchodilator treatments. Additional nursing supervision for symptom assessment and management (vital sign monitoring, lab/diagnostic test coordination and reporting)

**Maximum Benefit Period: 7 days.**

# Acute Care CHF

**Facility service(s) for onsite acute care treatment of a nursing facility resident with Congestive Heart Failure, (CHF). (May only be billed once per day per beneficiary). This service is for a demonstration project.**

**Qualifying Diagnosis:**

• Chest x-ray confirmation of a new pulmonary congestion

**OR TWO or more of the following:**

• Blood Oxygen saturation level below 92% on room air or on usual O2 settings in patients with chronic oxygen requirements.

**New or worsening pulmonary rales

**New or increased jugulo-venous distension

**New or worsening edema

**BNP > 300

**Symptomatic Guidance:** Acute onset of dyspnea (shortness of breath), orthopnea (SOB when lying down), paroxysmal nocturnal dyspnea (SOB waking the patient at night), new or increased leg or presacral edema, and/or unexpected weight gain.

Treatment: Increased diuretic therapy, obtain EKG to rule out cardiac ischemia or arrhythmias such as atrial fibrillation that could precipitate heart failure, vital sign or cardiac monitoring every shift, daily weights, oxygen therapy, low salt diet, and review of medications, including beta-blockers, ACE inhibitors, ARBS, aspirin, spironolactone, and statins, monitoring renal function, laboratory and radiologic monitoring. If new diagnosis, additional tests may be needed to detect cause.

Maximum Benefit Period 7 days

# Acute Care
# COPD/ASTHMA

**Facility service(s) for onsite acute care treatment of a resident with Chronic Obstructive Pulmonary Disease (COPD )or asthma. (May only be billed once per day per beneficiary). This service is for a demonstration project.**

**Qualifying Diagnosis:**

- Known diagnosis of COPD/Asthma or CXR showing COPD with hyper inflatedlungs and no infiltrates

***AND TWO or more of the following:***

- Symptoms of wheezing, shortness of breath, or increased sputum production
- Blood Oxygen saturation level below 92% on room air or on usual O2 settings in patients with chronic oxygen requirements
- Acute reduction in Peak Flow or FEV1 on spirometry
- Respiratory rate > 24 breaths/minute

**Treatment:** Increased Bronchodilator therapy, usually with a nebulizer, IV or oral steroids, oxygen, and sometimes antibiotics.

Maximum Benefit Period: 7 days

## Acute Care SKIN CARE/ INFECTION

**Facility service(s) for the onsite acute care treatment a nursing facility resident with a skin infection. (May only be billed once per day per beneficiary). This service is for a demonstration project.**

**Qualifying Diagnosis:**

- New onset of painful, warm and/or swollen/indurated skin infection requiring oral or parenteral antibiotic therapy
- If associated with a skin ulcer or wound there is an acute change in condition with signs of infection such as purulence, exudate, fever, new onset of pain, and/or induration.

**Treatment:** Frequent turning, nutritional assessment and/or supplementation, at least daily wound inspection and/or periodic wound debridement, cleansing, dressing changes, and antibiotics (oral or parenteral).

Maximum Benefit Period: 7 days

| | | |
|---|---|---|
| | **Acute Care**<br>**FLUID ELECTROLYTE DISORDER/ DEHYDRATION** | **Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration (May only be billed once per day per beneficiary). This service is for a demonstration project.** |

**Qualifying Diagnosis:**

- Any acute change in condition

**AND TWO or more of the following:**

- Reduced urine output in 24 hours or reduced oral intake by approximately 25% or more of average intake for 3 consecutive days
- New onset of Systolic BP < 100 mm Hg (Lying, sitting or standing)
- 20% increase in Blood Urea nitrogen (e.g. from 20 to 24) OR 20% increase in Serum Creatinine (e.g. from 1.0 to 1.2)
- sodium > 145 or < 135
- Orthostatic drop in systolic BP of 20 mmHg or more going from supine to sitting or standing.

Treatment: Parenteral (IV or clysis) fluids, lab/diagnostic test coordination and reporting, and careful evaluation for the underlying cause, including assessment of oral intake, medications (diuretics or renal toxins), infection, shock, heart failure, and kidney failure.

Maximum Benefit Period: 7 days

# Acute Care
# URINARY/UTI

**Facility service(s) for the onsite acute care treatment of a nursing facility resident for a urinary tract infection(UTI). (May only be billed once per day per beneficiary). This service is for a demonstration project.**

**Qualifying Diagnosis:**

- >100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms.

**AND One or more of the following:**

- Fever > 100° F (oral) or two degrees above baseline.
- Peripheral WBC count > 14,000.
- Symptoms of dysuria, new or increased urinary frequency, new or increased urinary incontinence, altered mental status, gross hematuria, or acute costovertebral angle pain or tenderness

**Symptomatic Guidance:** Dysuria, frequency, new incontinence, altered mental status, hematuria, CVA tenderness.

**Treatment:** Oral or parenteral antibiotics, lab/diagnostic test coordination and reporting, monitoring and management of urinary frequency, incontinence, agitation and other adverse effects.

Maximum Benefit Period: 7

# Practitioner Payment #2 for Care Coordination

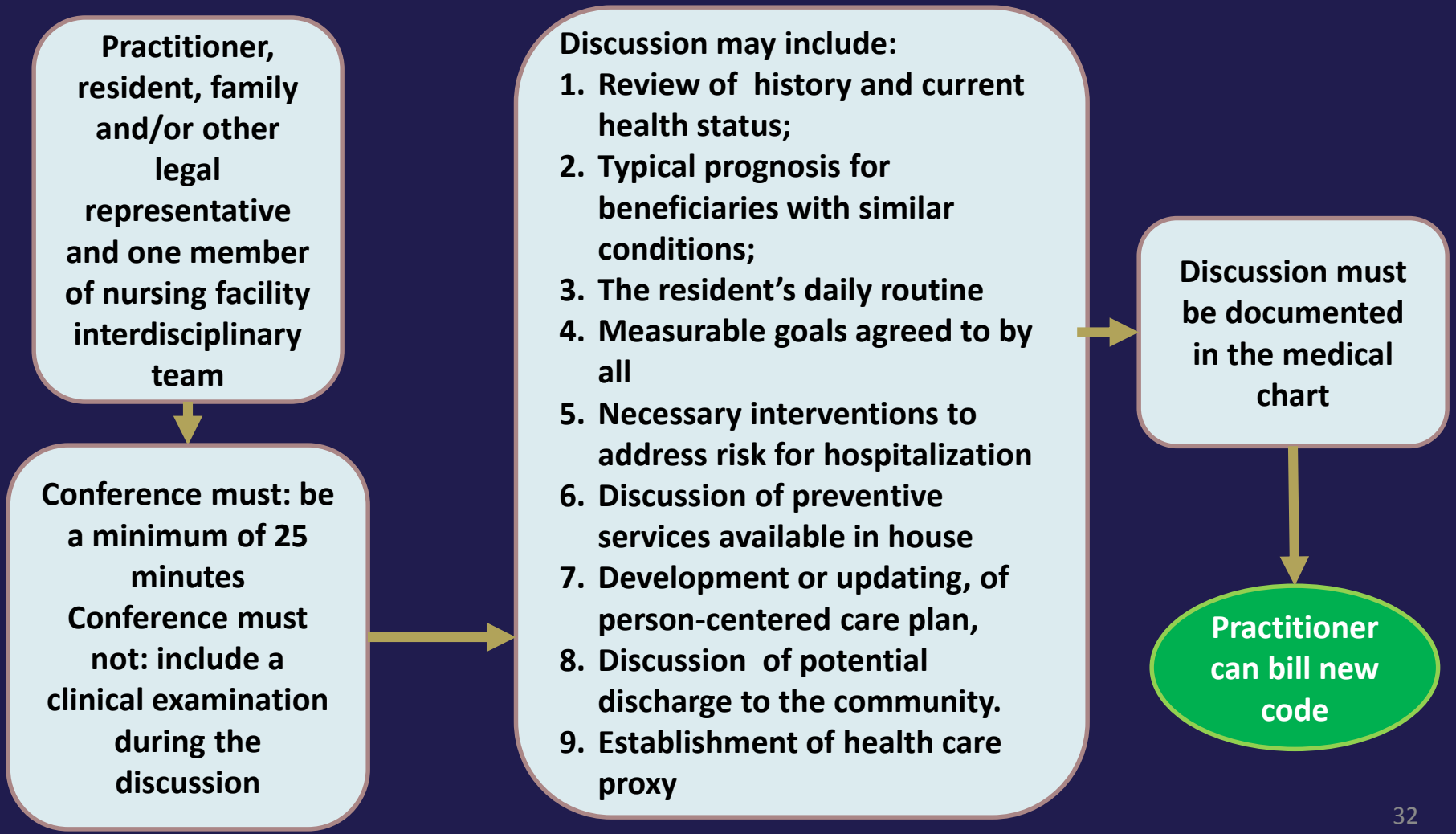
## Purpose

- Payment to create incentive for practitioners to participate in nursing facility conferences, and engage in care coordination discussions with beneficiaries, their caregivers, and LTC facility interdisciplinary team.

## Payment

- Billing Code G9686; Nursing Facility Conference

# Practitioner Payment #2 for Care Coordination *(cont'd)*



# Practitioner Payment #2 for Care Coordination *(cont'd)*

- Code can be billed within 14 days of significant change in condition that increases likelihood of hospital admission.
- If billed, change in condition must be documented in beneficiary's chart and reflected in comprehensive MDS assessment.

# Practitioner Payment #2 for Care Coordination *(cont'd)*

- If billed following a MDS significant change in condition, G9686 MUST be billed with a KX modifier.
- New MDS assessment is required only if it has been less than a year since the practitioner has billed for a care conference with this resident.

# Practitioner Payment #2 for Care Coordination *(cont'd)*

- CMS intends to waive any requirement for 20% beneficiary coinsurance or payment of deductible under the model.
- Code can be billed for beneficiaries in the target population when on a covered Medicare Part A SNF stay, as long as requirements listed above are met.

## NURSING FACILITY

**Participation in an onsite nursing facility conference, that is separate and distinct from an evaluation and management visit, including a physician, or other qualified health care professional and at least one member of the nursing facility interdisciplinary care team. This service is for a demonstration project.**

**Qualification Criteria**

In order to qualify for payment, the practitioner must conduct the discussion:

- With the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate);
- In a conference for a minimum of 25 minutes;
- Without performing a clinical examination of the beneficiary during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion); and
- Include at least one member of the LTC facility interdisciplinary team.
- The practitioner must also document the conversation in the beneficiary's medical chart.
- The change in condition should be documented in the beneficiary's chart and include a Minimum Data Set (MDS) assessment.

**Maximum Benefit Period:** The code can be billed only once per year or within 14 days of a significant change in condition that increases the likelihood of a hospital admission. Subsequent billing of this code after the first time must include a –KX modifier when processed. Failure to meet the significant change in condition threshold and include the –KX modifier will result in denial of subsequent claims.