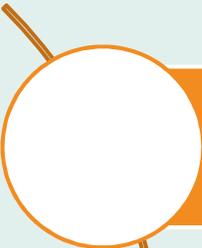


CMS Nursing Home Project New York-Reducing Avoidable Hospitalizations: Joining Phase Two



The webinar will begin shortly.



For audio, please dial (888) 390-3983 and mute the audio on your computer.



Thank you for your patience.



CMS Initiative to Reduce Avoidable Hospitalizations: Phase Two

April 21, 2016

Group A

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CMS Initiative to Reduce Avoidable Hospitalizations

Sponsored by Medicare-Medicaid Coordination Office in collaboration with Center for Medicare & Medicaid Innovation (CMMI)

- This project is NOT sponsored by CMS Division of Nursing Homes

Goals of the CMS Nursing Facility Initiative (NFI)

- Reduce frequency of avoidable hospital transfers
- Increase quality of care and reduce overall health care spending
- Improve transition process between hospitals and nursing facilities

Long-stay (101+ days) dually-eligible residents

- Participants in Medicare FFS only
- *No Medicare Advantage or FIDA plan enrollment*

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NY-RAH and Other NFI Projects

Seven projects across the US

- Alabama, Indiana, Missouri, Nebraska, Nevada, New York, Pennsylvania

Phase One: Sept 2012 – Sept 2016

- Promote use of communication tools: INTERACT curriculum; American Medical Directors Association (AMDA) tools
- Quality improvement strategies with a focus on the use of data and reports
- Promote palliative care strategies
- Support QAPI approaches
- Alignment with DSRIP participation

NY-RAH RN educator / consultant model

- Registered nurse care coordinator (RNCCs) placed at nursing facility to partner with staff and gather project data
- NY-RAH and AL are similar; others use clinical model with advanced practice nurses



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Phase One: 29 NY-RAH Facilities in NYC and Long Island



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Overview of Phase Two

Phase Two: March 2016 – Sept 2020

- CMS extension of Initiative to test what is ultimately the best way of promoting quality, cost-effective care
- Six participating projects received an award
- Only way for nursing facilities in New York to participate in the Initiative is through the NY-RAH project

Tests specific payment incentives

- Provide on-site treatment for six qualifying conditions
- Promote better care coordination



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Interplay with DSRIP & FIDA

NYS goal: decrease potentially avoidable hospitalizations by 25%

- NY-RAH participation supports DSRIP goals and will enhance a facility's work with a PPS

Nursing facilities in all New York counties eligible being considered for Phase Two

- Currently participating facilities will continue
- CMS will make ultimate decision regarding new participants and interplay with FIDA



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Phase Two Design

Group "A"

- NEW facilities
- NY-RAH seeking facilities for this new group
- Only payment reform
- CMS ultimately determines participating facilities

Group "B"

- Current facilities from Phase One
- Continues clinical and process interventions, RNCC role
- Payment reform added
- CMS hopes all facilities will proceed to Phase Two

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Target Population

Long-stay residents enrolled in Medicare fee-for-service (FFS)

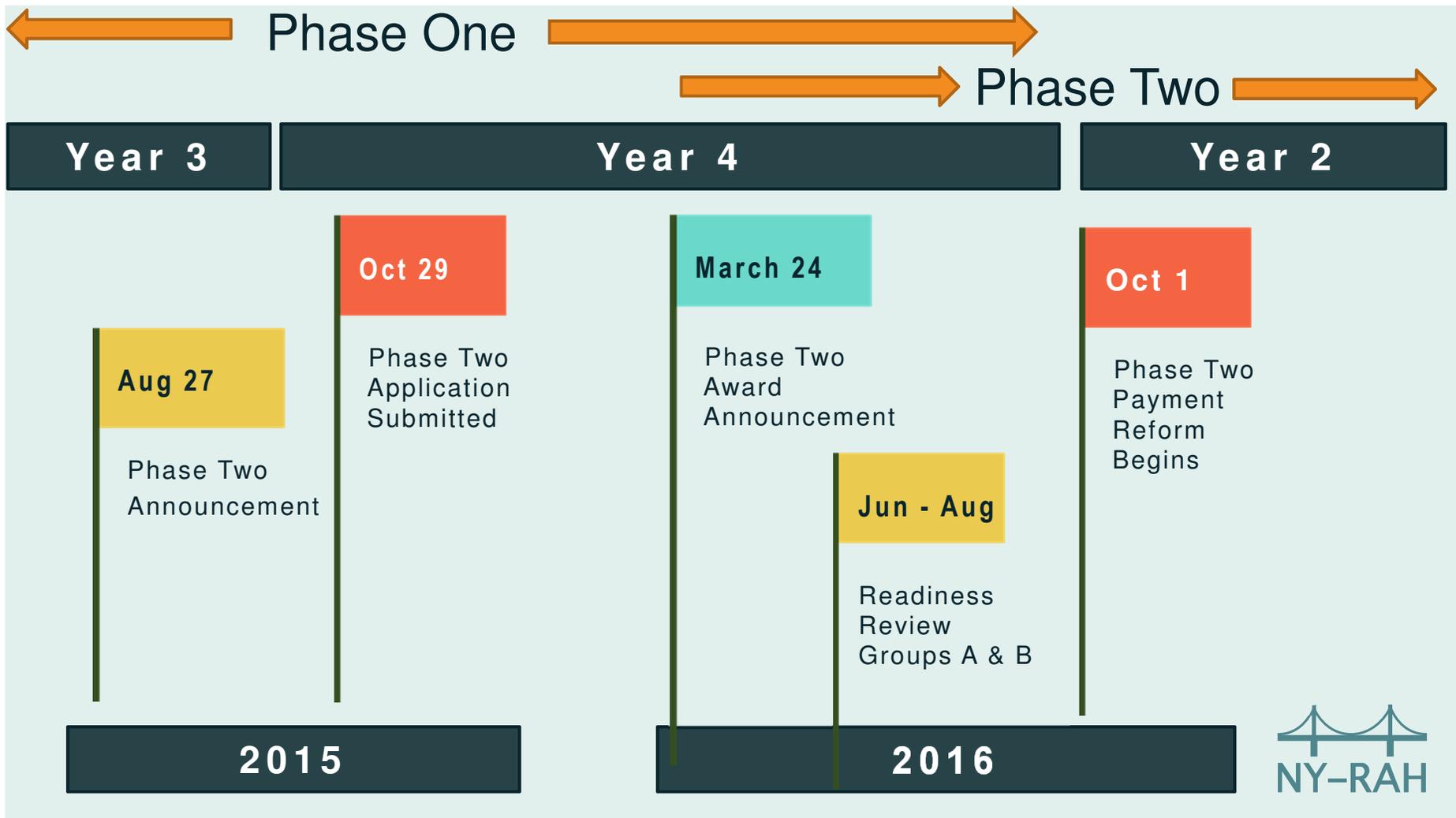
Length of stay of 101+ days since initial admission

Medicare FFS beneficiaries with Medicare as primary payer

Medicare FFS beneficiaries with Medicaid or private pay as primary payer

Not Eligible:
Any resident enrolled in a Medicare Advantage, ISNP, or FIDA plan

10 | Timeline of the Initiative



REQUIRED Group A Facility

Nursing Home Compare

- 3 stars or higher (as of Aug 27, 2015)

Size

- Facility must be 80 beds or larger

Long-Stay Medicare FFS

- At least 40% of SNF population is long-stay Medicare FFS residents

Medicare and Medicaid Participant

- Not excluded from participating in Medicare or Medicaid; and no sanctions against the facility

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PREFERRED Group A Facility

Large long-stay Medicare fee-for-service population (greater than 50% of facility and commitment to maintain the level)

Willingness to make changes to meet CMS requirements

Uses EMR and has RHIO membership

Long term commitment (September 2020)

Facility Vetting for Continued Participation

- CMS will implement regular checks that may lead to reconsideration of whether the facility should continue to participate in the Initiative

Potential for Reconsideration

- Facility is added to Special Focus Facility list
- Facility receives a survey deficiency for immediate jeopardy to resident health or safety

CMS retains the right to take action at any time if it believes:

- Improper practices are occurring
- Beneficiaries are not receiving enhanced care expected under this model

CMS Expectations Regarding Facility Resource Investment

Training

- Training from external consultants on preventative practices to avoid acute changes in condition
- Enhanced training of existing staff (e.g., parenteral therapy including intravenous (IV), intramuscular (IM), subcutaneous fluids or medications including antibiotics, complex wound care, etc.)
- Enhanced provision of nebulizer or respiratory therapy
- Implementation of quality improvement programs (e.g., INTERACT)

Care

- Increased nursing (e.g., RN) presence in the facility
- Contracts with external providers to provide assistance (e.g., LTC pharmacies, cardiologists, enhanced lab/diagnostic test coordination)

CMS Expectations Regarding Facility Resource Investment

(cont'd)

Resources

- Purchasing of tools that aid in the early identification and treatment of changes in conditions (e.g., AMDA tools)

Equipment

- New equipment as necessary to aid in assessments (e.g., bladder scanners, cardiac monitoring (EKG), arrhythmia management)

Technology

- Health information technology solutions that support the creation, exchange, and/or reuse of interoperable assessment data, care plans, and data at times of transitions in care

CMS Expectations Regarding Work with Contractors

Requests

- Participating facilities must respond to requests from CMS or its contractors for the purpose of oversight, monitoring, or evaluation
- Conference calls, data submission, chart reviews, site visits, and/or participation in surveys

Site Visits

- CMS contractor will conduct annual visits to select nursing facilities
- Evaluation contractor may conduct annual visits to determine implementation progress

Chart Audits

- CMS contractor will assess whether:
 - a beneficiary was eligible for billings
 - the nursing facility and practitioner followed the clinical criteria and recommendations
 - each beneficiary received appropriate care in the appropriate setting

CMS Expectations Regarding Data Collection

Participating facilities must agree to collect and share data as requested by CMS

Areas of data collection:

- To understand the use of billing codes
- To support practitioner participation

CMS will determine which data elements must be collected prior to October 1, 2016

GNYHA will work with facilities regarding training

CMS will add new codes to the Medicare Part B schedule specifically for this Initiative

- **New facility payment** for treatment of six qualifying conditions
- **Enhanced practitioner payment** for the treatment of conditions onsite at the nursing facility
- **New practitioner payment** for care coordination and 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

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%

Note: National data drove the identification of the six qualifying conditions and the overall payment reform intervention

Payment to Nursing Facility for Qualifying Conditions

Purpose

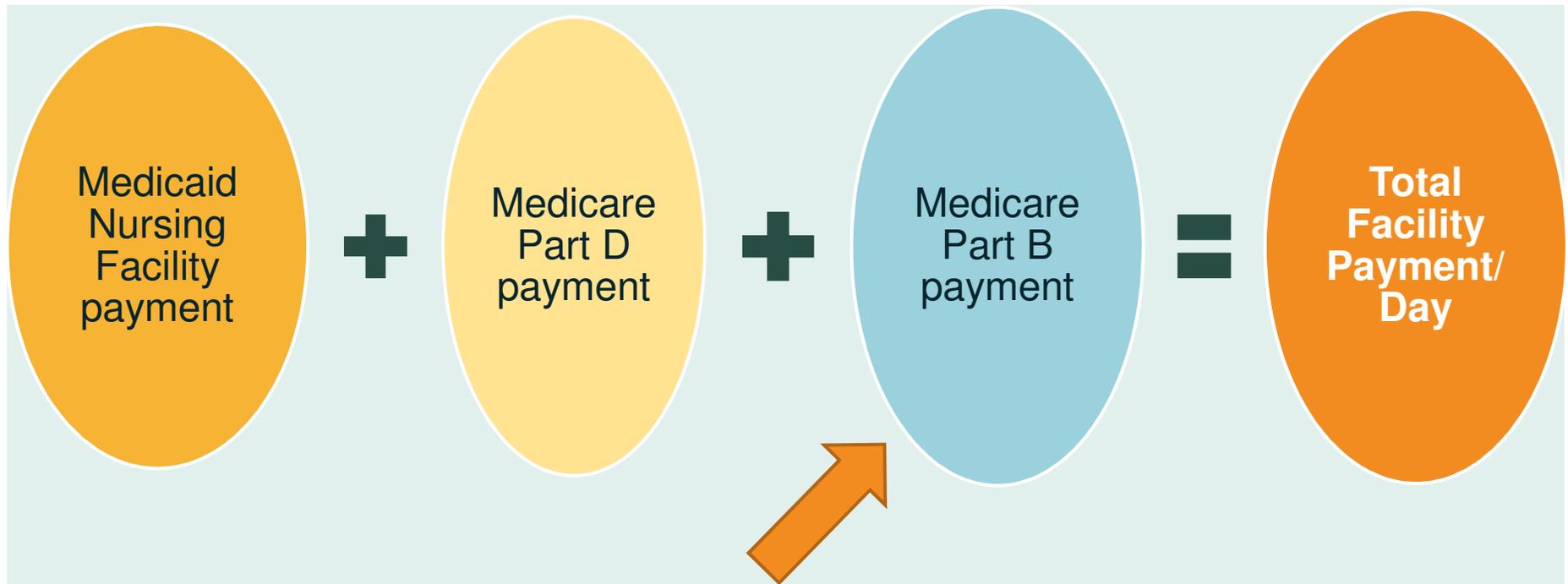
- Create incentive for facility to invest additional time and resources – beyond what is currently required – to furnish services and treat beneficiaries in-house

Payment

- “Onsite Acute Care”: \$218 per day
- Limited to 5-7 days, based on qualifying condition
- Limited to residents **not** on a covered Medicare Part A SNF stay

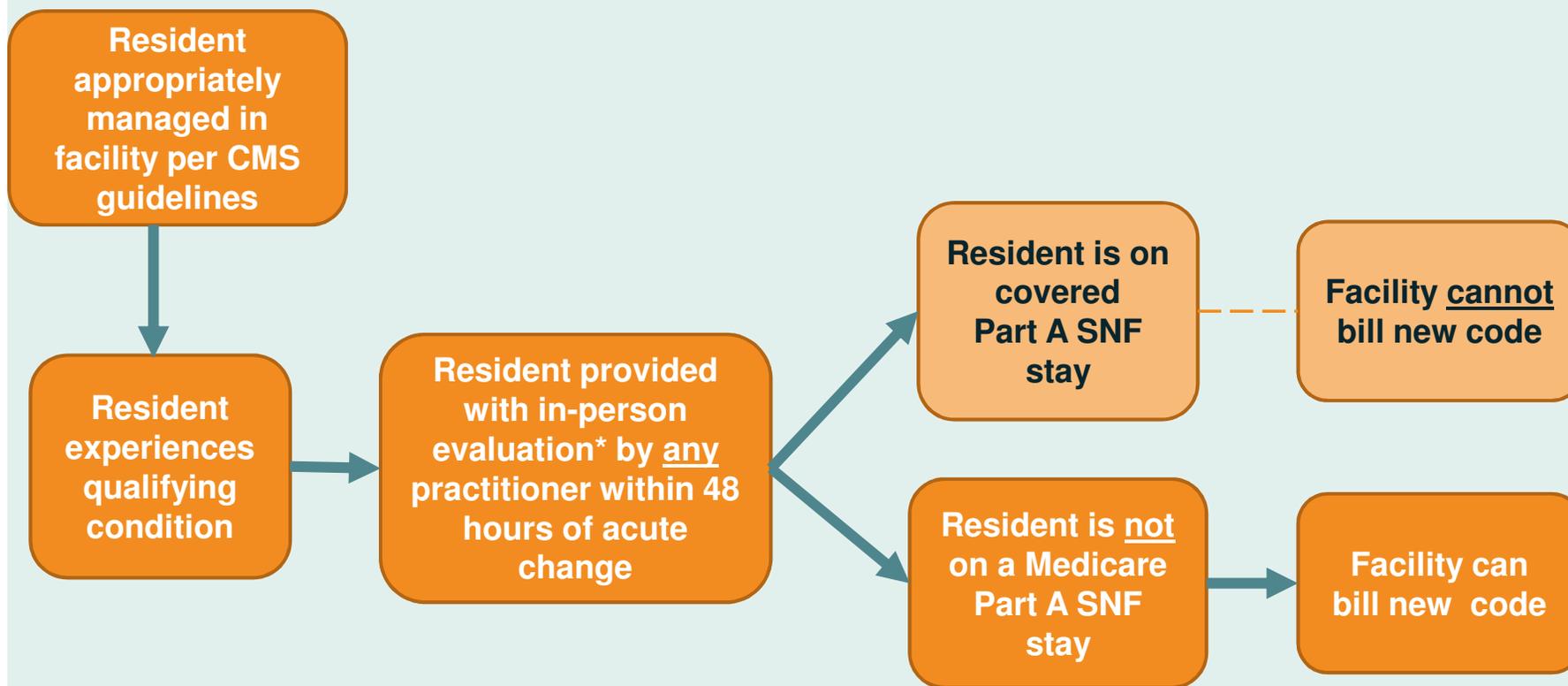
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Payment to Nursing Facility for Qualifying Conditions *(cont'd)*



New code added for the participating nursing facilities

22 | Facility Payment Scenario



* Or qualifying telemedicine assessment

Payment to Nursing Facility for Qualifying Conditions *(cont'd)*

Services Required

- CMS has specified exactly what clinical criteria must be met for each condition in order to bill
- Facility must ensure it is capable of providing expected services for the six conditions
- Facility enhancements to be made (if necessary) during 2016 readiness review period (Summer 2016)

Other Requirements

- In-person practitioner evaluation by the end of Day 2 following identification of acute change of condition

Clinical Criteria Example: COPD / Asthma

Facility services for onsite acute care treatment

Maximum Benefit Period: 7 days

Qualifying Diagnosis

- Known diagnosis of COPD/Asthma or CXR showing COPD with hyperinflated lungs and no infiltrates

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, or oxygen
- Sometimes with antibiotics

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Payment to Practitioner for Six Qualifying Conditions

Purpose

Incentivize practitioners (MD, NP, PA) to conduct visit to nursing facility resident to treat acute change in condition

Equalizes practitioner payment regardless of service being provided in hospital vs. nursing facility setting

Payment

Code used only for **initial** visit onsite at the SNF in response to acute change

Permitted to bill this code even if exam or labs ultimately reveal that resident does not have particular condition

Code can be billed even if resident in the target population is on a covered Part A SNF stay

Payment to a Practitioner for Six Qualifying Conditions

LTC FACILITY VISIT			Equivalent Hospital Visit		NEW PAYMENT		
CPT Code	Descriptor	Medicare Payment	Equivalent CPT Code	Medicare Payment	Code	Descriptor	Medicare Payment
99310	Nursing facility care, subsequent	\$137.80	99223	\$205.82	TBD	Acute Nursing Facility Care	\$205.82

Note 1: these figures are the base amounts and are subject to geographical adjustment

Note 2: NPs and PAs are reimbursed at 85% of physicians

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Payment to Practitioner for Six Qualifying Conditions

Clinical
Requirements

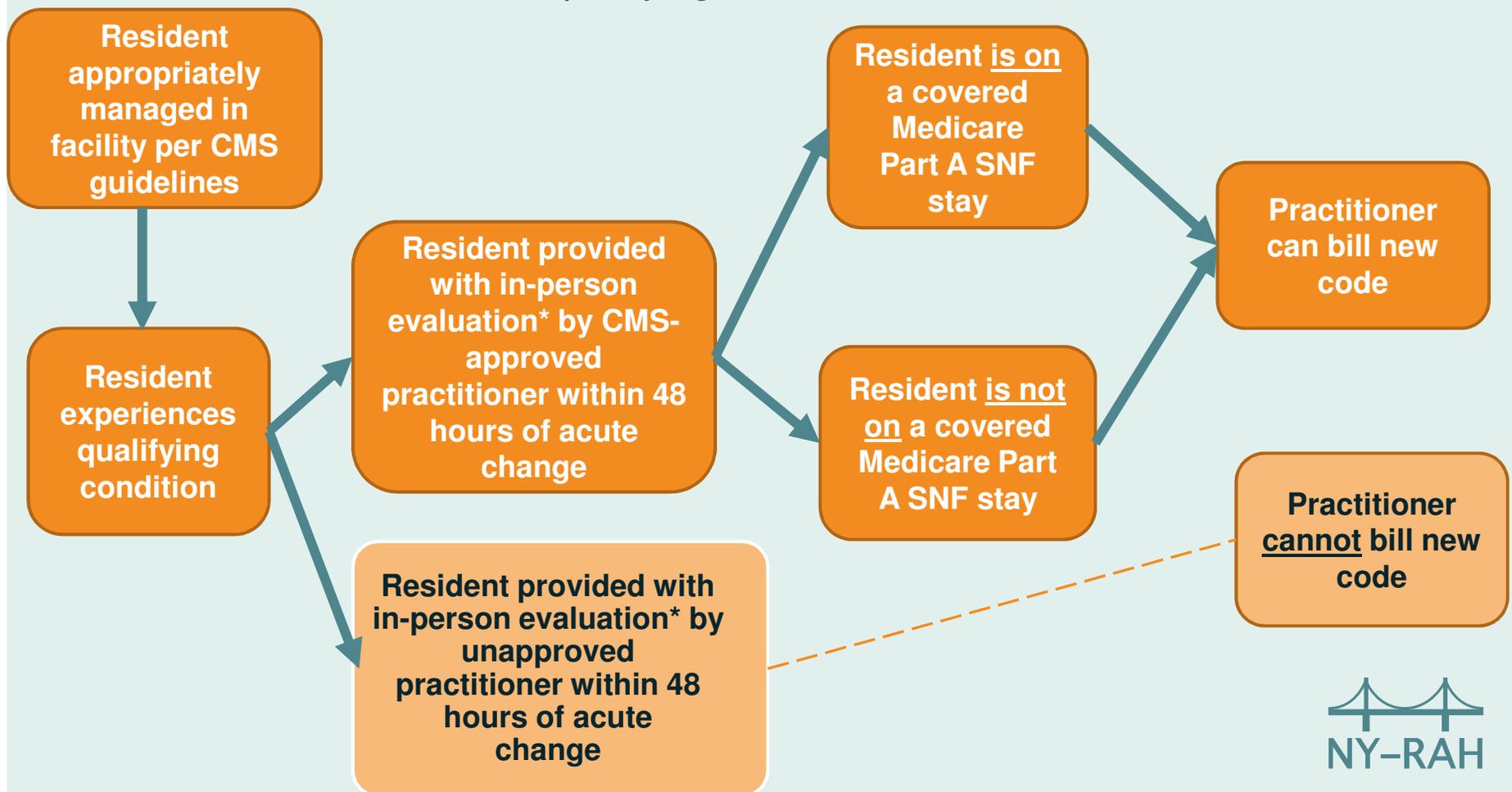
Comprehensive review of the beneficiary's history

A comprehensive examination

Medical decision-making of moderate to high complexity

Includes counseling and/or coordinating care with nursing facility staff and other providers or agencies

* Or qualifying telemedicine assessment



Practitioner Eligibility

Carried an average daily panel of **at least seven long-stay Medicare FFS** beneficiaries in your facility

Practitioners must consistently meet criteria for **six months**

Nurse Practitioners,
Physician Assistants,
and Physicians

No sanctions imposed in the last three years relating to billing practices

Licensure and certification in good standing;
Not excluded from participation in the Medicare or Medicaid programs

Payments to Practitioner for Care Coordination

Purpose

- Increase practitioner involvement in care coordination with beneficiary and/or engagement with individuals authorized to make health care decisions on behalf

Code	Descriptor	Medicare Payment
TBD	Nursing Facility Conference	\$77.64*

Note 1*: this figure is the base amount and is subject to geographical adjustment

Note 2: NPs and PAs are reimbursed at 85% of physicians

Payments to Practitioner for Care Coordination

Discussion items with resident

History of present illness and current health status

Development, updating, or confirmation of a person-centered care plan including improvements in daily routine

Measurable goals agreed to by resident, caregiver(s), and interdisciplinary care team

Typical scenarios or prognosis for the condition; risk for hospital transfers; and necessary interventions to address underlying risk factors

Clinically appropriate preventive services and facility's ability to treat certain conditions in-house

Establishment of a health care proxy where necessary

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Payments to Practitioner for Care Coordination

Billing Requirements

Conference must include the beneficiary or authorized decision maker

Must last a minimum of 25 minutes

No clinical exam during the discussion

Must include at least one member of the nursing facility interdisciplinary team

Documentation of the discussion in the patient chart

Can only be billed once per year in absence of a significant change in condition

Requirements for Interested Group A Facilities

Facility Data Survey

Will be sent to webinar registrants following the webinar

Should be completed by facility Administrator

Facilities that submitted a Fall 2015 application must submit again

Due April 29

Letter of Intent & Practitioner Grid

To be sent to prospective Group A facilities in early May

Due in mid-May

Complete a survey in Survey Monkey

- A PDF of the questions will be provided along with the link to the survey

Required information

- Facility characteristics
- Eligibility
- Technology capabilities
- Current clinical capabilities for the six qualifying conditions

Requirements for Interested Group A Facilities

Practitioner LOI's

To be sent to prospective facilities in late May

All practitioners that are listed on the practitioner grid **MUST** complete a letter of intent

Due in early June

Readiness Review

Review will occur from approximately June 1 – Aug 31, 2016

Details from CMS will be forthcoming

Phase Two contractor will perform a “Readiness Review” for CMS

- Facilities must be ready by Sept 1, 2016 to start billing on Oct 1, 2016

Readiness Review entails CMS working with:

- Law enforcement to vet facilities and practitioners
- CMS contractor to review facility and practitioner information, including ensuring facility has all necessary clinical capabilities and corresponding policies in place for the six qualifying conditions

Next Steps

By Friday morning, you will receive an email from Ashley Hammarth, NY-RAH Deputy Project Director

- Facility data survey (web link and PDF), webinar slides, CMS Guidance for Participating Facilities (contains Clinical Criteria)

Complete Group A survey by Friday April 29

NY-RAH will screen facilities based on survey results and create a list of prospective facilities for CMS

- Prospective facilities will receive a Letter of Intent template and Practitioner Grid in early May
- CMS will review list and ultimately determine Group A participation

If you have any questions please contact Ashley Hammarth at ahammarth@gnyha.org or 212-506-5421