DEPARTMENT OF HEALTH & HUMAN SERVICES
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Medicare-Medicaid Coordination Office

Updated Guidance on Resident Eligibility for the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform

Last updated April 20, 2016

CMS is issuing updates and clarification on some of the beneficiary eligibility criteria for the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform (the Initiative). This guidance is aimed at providers and other stakeholders that intend to partner with awarded enhanced care and coordination providers (ECCPs).

The below guidance provides updates and clarifications from the Funding Opportunity Announcement (FOA) issued on August 27, 2015 which can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NFInitiativePhaseTwoFOA.PDF.

Updates include:

- We are modifying the beneficiary eligibility criteria for the Initiative to exclude beneficiaries enrolled in Medicare hospice.
- We are modifying the beneficiary eligibility criteria for the Initiative to exclude beneficiaries receiving Medicare through the Railroad Retirement Board (RRB).
- We are clarifying several unusual eligibility scenarios.
- We are clarifying language on serving non-Medicare enrollees in the ECCP+Payment Group.

Hospice Exclusion

We are modifying the beneficiary eligibility criteria for the Initiative to exclude beneficiaries enrolled in Medicare hospice. The reasons for this exclusion are the following:

- Under the initiative, we are partnering with LTC facilities to provide enhanced skilled nursing care to eligible residents who meet the criteria for inclusion in the Initiative. For beneficiaries who have elected hospice, the hospice and not the LTC facility is responsible for providing a comprehensive set of services, including nursing services.
- It is CMS longstanding view that hospices are required to provide virtually all the care that is needed by terminally ill patients. This would include treatment for all conditions related to or brought on by the terminal condition as a result of the interdependence of

bodily systems, including the six conditions for which LTC facilities can bill Part B under the initiative. As a result, LTC facilities will not be entitled to new Initiative payments for treatment of these conditions when Medicare is separately paying the hospice for a comprehensive set of services, including treatment of conditions related to the terminal condition of the hospice enrollee.

- For beneficiaries who elect hospice, the plan of care is established and periodically reviewed and updated with the participation of the hospice physician and payment for these services is included in the hospice rate. Therefore, practitioners will not be entitled to new Initiative payments for the care coordination and caregiver engagement (Nursing Facility Conference) code under the Initiative.

RRB exclusion

We are modifying the beneficiary eligibility criteria for the Initiative to exclude beneficiaries receiving Medicare through the Railroad Retirement Board. CMS cannot implement the payment reform elements of this Initiative for these beneficiaries because some financial transactions remain under the jurisdiction of the RRB, so CMS cannot implement all of the necessary payment adjustment procedures for this population. These beneficiaries have a Medicare ID beginning with a letter rather than a number.

Eligibility Criteria for Payment Reform

The modified eligibility criteria for the Initiative are as follows:

Fully Eligible Population
For the clinical and payment interventions, the eligible beneficiary population (in any group) is defined as beneficiaries who meet the following criteria:

- Have resided in the LTC facility for 101 cumulative days or more starting from the resident's date of admission to that LTC facility[1]
- 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
- Reside in a Medicare or Medicaid certified LTC facility bed
- Are NOT enrolled in a Medicare Advantage plan
- Are NOT receiving Medicare through the Railroad Retirement Board
- Have not elected Medicare hospice

Unusual situations

- If an eligible resident elects the Medicare hospice benefit, but later discontinues that benefit, that individual's eligibility would be restored as long as other criteria remain applicable. Days in hospice do *not* count toward the 101 day minimum.
- Similarly, a resident who enrolls in Medicare Advantage and later disenrolls would also have their eligibility restored. In this case, the days of residence during Medicare Advantage enrollment *would* count toward the 101 day minimum.

Note: It is not required that the resident be in the facility for 101 *consecutive* days. However, gaps of 60 days or more are not permitted. If a former resident is readmitted 60 days or more after the previous discharge, the resident will not be eligible until an additional 101 days of residence.

- For shorter gaps, facilities are responsible for ensuring that an individual meets the cumulative 101 day residency minimum before any new claims are submitted under this Initiative. Facilities should consider collaborating with their ECCP partners to track resident eligibility.

CMS reserves the right to remove providers from this Initiative if they regularly submit claims relating to ineligible individuals.

[1] Should an eligible beneficiary transfer to another facility participating in the demonstration, the individual would not be eligible until 101 days from the date they were admitted to the new facility.

Special Rules for ECCP+Payment Group

Two special eligibility categories apply to the ECCP+Payment Group.

1) **Partially-Eligible Populations**

   Although Medicare Part B enrollment is required for Payment Reform interventions (see above), non-Medicare enrollees may continue to participate in the clinical and educational interventions in the ECCP+Payment Group as long as the other eligibility criteria are met.

   These partially-eligible populations may remain eligible for the clinical and educational ECCP interventions continuing from the previous phase *for the entire duration of the Initiative*.

   As described in the FOA, this category includes long-stay beneficiaries enrolled in Medicaid or receiving benefits from the Veterans Administration, but who are not enrolled in Medicare.

2) **Previously-Eligible Individuals**

   All other individuals receiving ECCP clinical services as of September 30, 2016 remain eligible for the ECCP clinical interventions until discharge. These include short-stay residents without a discharge plan and residents who have elected hospice. After September 30, no new residents in these categories may become eligible for payment or clinical interventions.

   Data collection standards described in the Updated Guidance for Participating Facilities do not apply to these "grandfathered" individuals.

ECCPs should contact CMS if there are any other unusual situations not described above.