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Medicare-Medicaid Coordination Office

Updated Guidance for Long-Term Care (LTC) Facility Participation in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform

Last updated December 10, 2018

CMS is issuing updates and clarification on some of the rules and requirements for LTC facility participation in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform (the Initiative). This guidance is aimed at LTC facilities 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) originally 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 from previous versions of this Guidance include:

- Updating clinical criteria for billing can be found on the NFI web site: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/Downloads/NFIHCPCSCodesAndClinicalCriteria_12019.pdf

Background: Payments to a facility for treatment of qualifying conditions
(for beneficiaries not on a covered Medicare Part A SNF stay)

Research shows that six conditions have been linked to approximately 80% of potentially avoidable hospitalizations among LTC facility residents (see Table 1).

Table 1: Share of potentially avoidable hospitalizations

Condition	Percentage
Pneumonia	32.8%
Dehydration	10.3%
Congestive Heart Failure (CHF)	11.6%
Urinary Tract Infection (UTI)	14.2%
Skin ulcers, cellulitis	4.9%
COPD, asthma	6.5%
TOTAL	**80.3%**

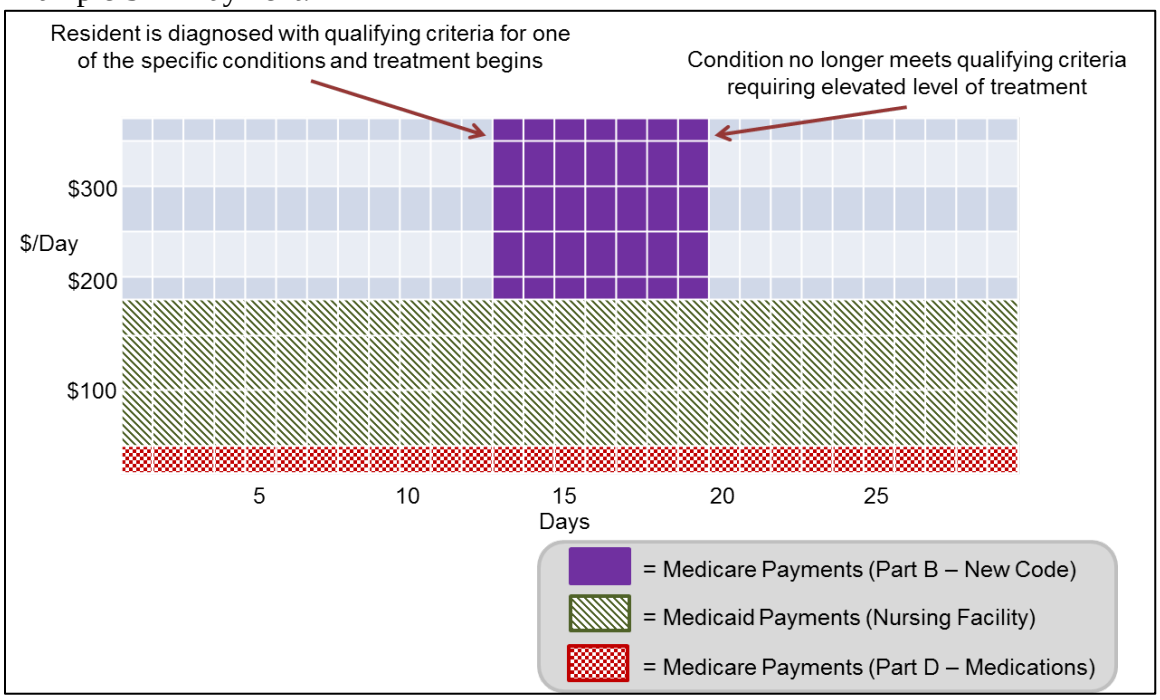
Examples of some of the activities required to treat these conditions include the ability to provide the following:

- Early identification of resident changes in condition;
- Parenteral therapy including intravenous (IV), intramuscular (IM), or subcutaneous fluids or medications including antibiotics;
- Nebulizer or respiratory therapy;
- Cardiac monitoring and arrhythmia management;
- Additional nursing services for lab/diagnostic test coordination and reporting; and/or
- Complex wound dressing changes.

To create an incentive for facilities to invest the additional time and resources—beyond what they are required to do today—to furnish services and treat beneficiaries in-house without transferring to the hospital, the first component of the model is a new code category billable by the SNF under Medicare Part B for the treatment of the **above six conditions only**. The payment will be approximately $218 per day.

CMS is waiving any requirement for a 20% beneficiary coinsurance or payment of a deductible under the model; therefore the $218 per day payment is the total payment amount.

Example SNF Payment:



The model would provide payment to LTC facilities for increased services to treat the conditions. We expect that LTC facilities would invest the additional resources to develop processes and capabilities above what is currently the norm in order to improve outcomes and reduce avoidable hospitalizations. For example:

- Implementation of quality improvement programs (e.g., INTERACT)
- Training from external consultants on preventative practices to avoid acute changes in condition
- Purchasing of tools that aid in the early identification and treatment of changes in conditions (e.g., AMDA tools)
- Increased nursing (e.g., RN) presence in the facility
- 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
- Contracts with external providers to provide assistance (e.g., LTC pharmacies, cardiologists, enhanced lab/diagnostic test coordination)
- New equipment to aid in assessments (e.g., bladder scanners, cardiac monitoring (EKG), arrhythmia management)
- 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.

Under this model, facilities may continue to provide other services as needed and bill for them separately, just as they can today. For example, other Part B services such as physical therapy could still be furnished and paid as they are under the current system, and we would expect the

treatment plan established by the physician or other practitioner to include these services as appropriate.

In addition to the above, when LTC facility participation is coupled with an ECCP intervention in the ECCP+Payment Group, the impact of the payment model would be magnified. For example:

- ECCP RN trainers would enhance the training of quality improvement programs.
- ECCP NPs would represent an increased availability of qualified practitioners to be onsite to assess and engage beneficiaries in care planning conferences.[1]
- The presence of other ECCP clinicians (e.g., RN, SW, pharmacy techs) and interventions (e.g., telemedicine) onsite would enable broader and more rapid education and ability to address beneficiaries' needs.

[1] Note: ECCP staff are not permitted to bill Medicare for services provided as a part of this Initiative.

LTC Facility Regulatory and Demographic Eligibility Criteria for Participation in Group A (Payment-Only Group)

The Payment-Only group is only open to newly-recruited facilities. To participate in the Payment-Only Group, a facility must:

- Not be on the CMS list of Special Focus Facilities;
- Have no survey deficiencies for immediate jeopardy to resident health or safety within the last 12 months (the 12 month period preceding April 1, 2016);
- Not had any sanctions, indictments, probations, corrective action plans, or judgments imposed in the last three years relating to fraudulent or abusive billing practices;
- Be Medicare and Medicaid certified and not excluded from participation in the Medicare or Medicaid programs;
- Have an average daily census of greater than 80 residents with greater than 40% of the total LTC facility census as long-stay [defined as a beneficiary who has resided in the LTC facility for 101 days or more] Medicare enrollees in traditional FFS Medicare (not enrolled in Medicare Advantage); *and*
- Have at least a three star overall rating on Nursing Home Compare on the date of the Funding Opportunity Announcement (August 27, 2015)

LTC Facility Regulatory and Demographic Eligibility Criteria for Participation in Group B (ECCP+Payment Group)

The ECCP+Payment Group is only open to facilities that have participated in the Initiative during the initial phase. To continue full participation in the Initiative, a facility must…

- Not be on the CMS list of Special Focus Facilities;
- Not had any sanctions, indictments, probations, corrective action plans, or judgments imposed in the last three years relating to fraudulent or abusive billing practices; *and*
- Be Medicare and Medicaid certified and not excluded from participation in the Medicare or Medicaid programs

CMS retains the right to modify or waive any of the required criteria for participation and the right to approve or terminate any LTC facility's participation in the Initiative. See LTC Facility Vetting, below.

LTC Facility Vetting for Continued Program Participation

To protect the integrity of program and safeguard beneficiaries, CMS will implement regular vetting checks of participating nursing facilities.

For example, if a facility is added to the Special Focus Facility list, or is found to have received a survey deficiency for immediate jeopardy to resident health or safety, CMS will reconsider whether the facility should continue to participate in the Initiative.

CMS retains the right to take action (e.g. termination, suspension, withholding payments) at any time throughout the Initiative if CMS believes that improper practices are occurring or beneficiaries are not receiving the enhanced care expected under this model.

Payments to a LTC Facility for Treatment of Qualifying Conditions

CMS is updating language proposed in the FOA released on August 27, 2015. Specifically, this includes the confirmation requirements and the duration of the benefit.

Payment to a LTC facility for Onsite Acute Care are subject to all of the below criteria:

- **Confirmation**: The confirmation of the qualifying diagnosis and the prescription of treatment by an attending practitioner at the facility.
    - This confirmation must include an in-person evaluation by a practitioner, or a qualifying telemedicine assessment with minimum system requirements as determined by CMS (see page 17), by the end of the 2nd day after a change in condition. This evaluation must be documented in the resident's medical record.
    - The in-person practitioner evaluation is a separately billable service and is not included in the Onsite Acute Care payment.
        - If performed by a non-ECCP practitioner (e.g. attending physician), the visit is billed separately by the practitioner[2], either using the Initiative's new evaluation & management (E&M) code or using an existing Medicare E&M code.
        - ECCP practitioners (e.g. NPs) may conduct the visit to confirm the diagnosis to qualify the LTC facility for payment. In this case, Medicare is not billed (consistent with the terms and conditions of the Initiative) but ECCPs are required to provide comparable information to CMS in lieu of a claim.
    - The LTC facility *may* also need to complete a Minimum Data Set (MDS) Significant Change in Status Assessment, following standard MDS requirements (not included in the Onsite Acute Care payment).

- **Duration of Benefit:** As indicated in the descriptions below, there is a maximum duration of benefit for each of the six conditions. Nevertheless, the benefit can be triggered again if the beneficiary continues to meet the qualifying criteria for one of the qualifying conditions. There is no requirement for a gap between benefits if the condition continues to meet the qualifying criteria after the maximum benefit period, but a new assessment is required.

  Regardless, as with any other Medicare services, the facility should discontinue billing once the underlying condition has improved and enhanced services are no longer medically necessary.

  Similarly, if the qualifying diagnosis (or set of multiple qualifying diagnoses) changes at any time during the benefit period, the facility should discontinue the initial billing and instead begin a new benefit period based on the new qualifying diagnosis (or set of

[2] Use of a qualifying telemedicine assessment is sufficient for the facility payment, but for the practitioner payment, standard CMS telemedicine rules apply. As long as the confirmation of the qualifying diagnosis occurs, as specified above, the LTC facility may bill for Onsite Acute Nursing Facility Care even when a practitioner does not or cannot bill.

qualifying diagnoses).

Finally, none of these codes should be billed for a day in which the resident is discharged.

- **Limitation of Benefit:** None of these codes may be billed more than once a day for a single beneficiary. No more than one of these codes may be billed in a day for a single beneficiary, even if that beneficiary has more than one of the six conditions being treated in the facility.

- **Qualifying Criteria**: Each of the six conditions has qualifying criteria defining the clinical or diagnostic conditions of a beneficiary that could trigger the benefit. The final criteria for each of the six conditions are detailed below: As noted above, confirmation of any of the six conditions: must include an in-person evaluation by a practitioner or a qualifying telemedicine assessment with minimum system requirements as determined by CMS.

  Updated criteria taking effect January 1, 2019, can be found on the NFI site:

  https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/Downloads/NFIHCPCSCodesAndClinicalCriteria_12019.pdf

  Original criteria for services on or before December 31, 2018 can be found below **for reference only**.

Purpose	***Description***	***LTC Facility Clinical Criteria (2016-2018 ONLY)***
Acute care pneumonia (G9679)	Facility service(s) for onsite acute care treatment of a nursing facility resident with pneumonia.	***Pneumonia:*** Qualifying Diagnosis: • Chest x-ray confirmation of a *new* pulmonary infiltrate; or • Two or more of the following: o Fever >100 º F (oral) or two degrees above baseline o Blood Oxygen saturation level < 92% on room air or on usual O2 settings in patients with chronic oxygen requirements. o Respiratory rate above 24 breaths/minute o 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.

Purpose	*Description*	*LTC Facility Clinical Criteria (2016-2018 ONLY)*
Acute care congestive heart failure (CHF) (G9680)	Facility service(s) for onsite acute care treatment of a nursing facility resident with congestive heart failure (CHF).	***Congestive Heart Failure*** Qualifying Diagnosis: • Chest x-ray confirmation of a *new* pulmonary congestion, or • Two or more of the following: o Blood Oxygen saturation level below 92% on room air or on usual O2 settings in patients with chronic oxygen requirements. o New or worsening pulmonary rales o New or worsening edema o New or increased jugulo-venous distension o 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

Purpose	*Description*	*LTC Facility Clinical Criteria (2016-2018 ONLY)*
Acute care chronic obstructive pulmonary disease (COPD) /asthma (G9681)	Facility service(s) for onsite acute care treatment of a resident with chronic obstructive pulmonary disease (COPD) or asthma.	***COPD/Asthma*** Qualifying Diagnosis: • Known diagnosis of COPD/Asthma or CXR showing COPD with hyperinflated lungs 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 infection (G9682)	Facility service(s) for the onsite acute care treatment a nursing facility resident with a skin infection.	***Skin Infection*** Qualifying Diagnosis: o New onset of painful, *warm and/or swollen*/indurated skin infection requiring oral or parenteral antibiotic or antiviral 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

Purpose	*Description*	*LTC Facility Clinical Criteria (2016-2018 ONLY)*
Acute care fluid or electrolyte disorder or dehydration (G9683)	Facility service(s) for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration	***Fluid or Electrolyte Disorder, or Dehydration*** 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: 5 days
Acute care urinary tract infection (UTI) (G9684)	Facility service(s) for the onsite acute care treatment of a nursing facility resident for a urinary tract infection (UTI).	***Urinary Tract Infection*** 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 days

Requirements for Participation Agreements

LTC facilities must execute a participation agreement with the ECCP prior to passing the readiness review and participating in the payment model. This agreement must also attest or state the LTC facility's commitment to meeting and maintaining the criteria above, and other criteria listed in the FOA, through the end of the Initiative. As part of this participation agreement, LTC facilities must agree to collect and share data and information, in compliance with applicable privacy requirements, necessary for the operations and evaluation of the Initiative and the care of beneficiaries in accordance with regulations governing CMS payment and service delivery models (42 CFR 403.1110).

Data collection is a necessary component of program oversight, monitoring, evaluation, and integrity. CMS will prescribe the required data elements to be collected by both Payment-Only (Group A) and ECCP+Payment (Group B) facilities prior to the start of the program on October 1, 2016. Participating facilities and ECCPs will work together to determine the most efficient method of data collection and to sign any legal agreements for the sharing of beneficiary data that may be necessary, in accordance with applicable privacy law. ECCPs will be responsible for compiling and reporting the data to the CMS operations support contractor.

Failure to comply with data collection standards under 42 CFR 403.1110 may result in a facility's termination from the Initiative.

Operations Support Contract Site Visits and Chart Reviews

Participating LTC facilities must also agree to respond to requests from CMS or its contractors (operations support contractor or evaluation contractor) for the purpose of oversight, monitoring, or evaluation. This may include requests to participate in conference calls, submit data, conduct chart reviews, conduct site visits, and/or participate in surveys.

As part of program monitoring and to ensure integrity of the program, the operations support contractor will conduct yearly site visits to select nursing facilities to conduct chart reviews. These chart reviews will determine whether a beneficiary was eligible for billings, whether the nursing facility and practitioner followed the clinical criteria and recommendations, and whether each beneficiary received appropriate care in the appropriate setting. Claims data will be used in conjunction with site visits for program monitoring.

Contactors may request access to appropriate medical records and other information necessary during site visits and chart reviews. Failure to comply may result in termination from the Initiative.

LTC facility readiness review requirements

In addition to the eligibility criteria, LTC facilities also must provide documentation that they can enhance the prevention of the conditions and administer the necessary treatments at any time. This will be verified through the readiness review process prior to allowing LTC facilities to participate (LTC facilities may not have met the criteria at the time of application, but MUST meet the criteria in order to pass the readiness review and participate in the Initiative). The readiness review requirements include:

Prevention Criteria:

- The adherence to the conditions of participation and adoption of best practices related to prevention of the six targeted conditions.
- The implementation of a structured tool for identifying early signs of a potential change in a beneficiary's condition, that would require additional monitoring or other activities to prevent an acute change in condition.
- The creation of facility-wide policy and procedure that defines the process to be followed to prevent acute changes in condition (e.g., using the tools and guidelines referenced above). Policies and procedures should specifically identify, but not be limited to, the six targeted conditions. Also, policies and procedures must also describe the facility's process to transfer a beneficiary to the hospital (e.g., when the beneficiary cannot be safely treated in the facility, upon the physician's orders, at the beneficiary's or health care proxy's discretion).

LTC facilities must submit a sample or copy of the tool(s) to be used, evidence that all appropriate staff has been trained, and a copy of the policy and procedures.

Treatment Criteria:

- 24 hour availability (phone or in person) by LTC facility key staff (e.g., Medical Director, Administrator, Director of Nursing, RN manager, etc.) and attending practitioners (e.g., MP, NP, PA). RN onsite 24 hours per day preferred.
- The ability to start and maintain parenteral (e.g., IV, hypodermoclysis, etc.) medications and fluids 24 hours a day for eligible beneficiaries by a certified staff member on all units. LTC facilities may also contract with external companies licensed to furnish some of these services in the LTC facility (e.g., LTC Pharmacy).
- The ability to address complex wounds through debridement, high frequency dressing changes, cleansing, and antibiotics (LTC facility or external consultant).
- The ability to furnish respiratory and bronchodilator therapy, and oxygen 24 hours per day.
- The ability to furnish EKGs and access to a clinician (e.g., external consultant) to read and interpret EKGs within 2 hours (e.g., via letter of agreement stating availability and response time).
- The implementation and use of a structured tool to document and communicate a resident's change in condition, including hospital transfers (e.g., INTERACT, AMDA tools, etc.); see Required Elements for the Structured Tool, below. Note: Separate from this, LTC facilities may need to complete the MDS assessment for beneficiaries

experiencing a significant change in condition, in accordance with prevailing MDS requirements.

- Information and specifications of telemedicine system (if applicable)
- Information and specifications related to the health IT used to support assessments, care planning, and/or health information exchange at times of transitions in care.

Required Elements for the Structured Tool for Communicating and Documenting Resident Changes in Condition

Tools to communicate and document a resident's change in condition (including a hospital transfer) must contain the following categories in order to meet the criterion for the readiness review. Note: It is not required that categories be completed for each change in condition. Rather, that all information relevant to the change in condition be documented and communicated to assist in the decision making process for the best care of the resident.

- Beneficiary contact information (or health care proxy)
- Primary care team contact information
- Advance directive information
- Description of acute change in condition
- Past medical/surgical history
- Active diagnoses/current problem list and status
- Functional status
- Psychosocial assessment including cognitive status
- Social supports and behavioral health issues
- Medications
- Comprehensive care plan goals
- Treatments and other interventions
- Allergies
- Pertinent laboratory studies (e.g., INR, baseline BUN and creatinine, CXR, EKG, and previous work-up for the acute condition)
- Resident status
- Reason for transfer

Guidance for Qualifying Telemedicine Systems and Consultations

The following information provides guidance on the type of system capabilities, activities, and documentation that would allow a telemedicine consult to qualify as the practitioner visit for the first component of the payment model (and potentially qualifying the LTC facility to receive payment).

Reporting Requirements

Telemedicine systems should be able to provide the following reports to CMS in order to qualify for use under this Initiative:

- Utilization information such as a date and time stamp (e.g., date(s) used, start/stop time) and duration of consultation.
- Information on the clinicians (e.g., LPN, RN) and practitioners (e.g., MD, NP, PA) involved in the consultation and which LTC facility the event occurred in.
- Information about the beneficiary who received the consultation (in compliance with applicable privacy requirements).
- *Preferred:* Aggregated reporting capabilities such as total consults in a given timeframe (e.g., month) or LTC facility, or by practitioner, day of week, or time of day.

Technology (Hardware/Software)

A standard system should include a mobile medical cart with the ability to hold a PC, drawers for supplies, diagnostic medical equipment, and a rechargeable battery. The PC should be pre-loaded with necessary software, sound system, and high performance pan/tilt/zoom camera. Peripherals should include a stethoscope and light source to optimize viewing and assessment.

Enhanced systems may include a touch screen PC over the traditional PC and that the cart also is furnished with an otoscope and EKG System.

The system should include real-time interactive audio visual technology and not "store and forward" technology. All of the equipment should be connected using a secure wired or wireless system.

For some more specific details about the recommended technology:

- A secure wired/wireless internet connection with at least 5 MB/sec up and down
- A full-duplex USB or Bluetooth-enabled speakerphone
- At least one high-performance >/= 19x optical zoom, low light, pan/tilt/zoom camera
- A high-definition web-cam capable of 1080p video
- An electronic stethoscope (e.g., Bluetooth enabled) that allows for remote listening of heart, lungs, abdominal sounds
- A digital Otoscope to see the outer/middle ear, the eyes, mouth and throat (for enhanced systems)
- A PC-Based Resting 12-lead ECG/EKG System (for enhanced systems)

Telemedicine Consult and Documentation

The following activities should occur for the consultation to qualify for the practitioner confirmation criterion for the first component of the payment model (and potentially qualifying the LTC facility to receive payment):

- RN assessment qualifying a change in condition.
- RN and practitioner discuss the resident's condition (phone call, reviewing of records) to determine if a Telemedicine consultation is warranted (requirements would be similar to the requirements for CMS billing codes 99306-99310).
- A full H&P (meeting the criteria for billing codes 99306-99310) and describing that the consultation was completed using telemedicine, why an in-person visit was not feasible (telemedicine consultations should occur during off-hours and when there is no available practitioner on site), and confirmation that the beneficiary's condition meets the criteria for reimbursement under the Initiative.
- The documentation of the H&P needs to be transmitted and filed in the resident's chart.