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Next Generation ACO Model

Benefit Enhancements

March 28, 2017

Disclaimer

The comments made on this call are offered only for general informational and educational purposes. As always, the agency's positions on matters may be subject to change. CMS's comments are not offered as and do not constitute legal advice or legal opinions, and no statement made on this call will preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations. ACOs are responsible for ensuring that their actions fully comply with applicable laws, rules and regulations, and we encourage you to consult with your own legal counsel to ensure such compliance.

Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. CMS is not seeking group advice.

Agenda

- Benefit Enhancement Timeline
- Benefit Enhancements
  - 3-Day SNF Rule Waiver
  - Telehealth
  - Post-Discharge Home Visits
- Next Generation ACO Entities
  - Participant Providers
  - Preferred Providers
- Coordinated Care Reward
- Open Forum for Questions

Benefit Enhancement Timeline

Milestone	Date
LOI Due	May 4, 2017
Application Due	May 18, 2017*
Next Generation Participant List Due	June 9, 2017
Finalists Identified	August 2017
Next Generation Preferred Provider List Due	Fall 2017
Benefit Enhancements Implementation Plans Due	Fall 2017
Participation Agreements Signed	Late Fall 2017
Start of Performance Year	January 1, 2018

*The text of the application is currently available in Appendix G of the RFA. The application portal is open and is available via https://innovation.cms.gov/initiatives/Next-Generation-ACOModel/

Next Generation Participants and Preferred Providers

- The Model defines two categories of Medicare providers/suppliers with respect to the ACO:
  - Next Generation Participants
  - Next Generation Preferred Providers
- Next Generation Participants are the core providers/suppliers in the Model.
  - Used for beneficiary alignment.
  - Report quality through the ACO.
  - Commit to beneficiary care improvement objectives.
- Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO.
  - May participate in certain benefit enhancements and payment mechanisms.
  - Not used in alignment and do not report quality through the ACO.

Next Generation Participants

- NGACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
  - Physicians or others in group practice arrangements;
  - Networks of individual practices of physicians;
  - Hospitals employing physicians or other practitioners;
  - Partnerships or joint venture arrangements between hospitals and physicians or other practitioners;
  - Federally Qualified Health Centers (FQHCs);
  - Rural Health Clinics (RHCs); and
  - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers or suppliers, except Durable Medical Equipment (DME) suppliers and any other Prohibited Provider (as defined in the RFA), may participate in an ACO formed by one or more of the entities listed above.

Next Generation Preferred Providers

- Contribute to Next Generation goals by extending and facilitating valuable care relationships:
  - Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO;
  - May participate in benefit enhancements (as applicable);
  - May participate in PBP and AIPBP;
  - Services delivered to Next Generation beneficiaries count toward the coordinated care reward calculation (direct payments made to beneficiaries by CMS); and
  - Preferred Providers will **not** be associated with beneficiary alignment or used for quality reporting by the ACO.

Benefit Enhancements

- Conditional waivers of certain Medicare payment rules
- Goals:
  - Emphasize high-value services
  - Support care management and closer care relationships
  - Allow ACO flexibility
  - Promote communication to beneficiaries
  - Evaluate ACO utilization and impact
- To participate in Benefit Enhancements, a given Medicare provider or supplier must be a Next Generation Participant or Preferred Provider.
- Resource:
  - Medicare Learning Network Matters Article on the Next Generation ACO Model's Benefit Enhancements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1613.pdf

3-Day SNF Rule Waiver Overview

- Eliminate the requirement of a 3-day inpatient stay prior to SNF (or swing-bed CAH) admission.
  - Available to aligned beneficiaries of NGACOs that have elected to participate in the waiver
  - Beneficiary must be admitted to a SNF that is a Next Generation Participant or Preferred Provider approved for the waiver
  - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing or rehab need.

SNF, Swing-Bed Hospital or CAH Eligibility

- Review of SNF, swing-bed hospital, or CAH qualifications to accept direct admissions or admissions after an inpatient stay of fewer than 3 days includes:
  - Consideration of the program integrity history of the SNF and any other factors that CMS determines may affect the qualifications of the SNF
  - At the time of reviewing eligibility, any SNF must have an overall rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website.
- SNFs are identified using CCN and organizational NPI
- Annual reassessment of SNF, swing-bed hospital, or CAH eligibility prior to the start of each Performance Year

SNF Beneficiary Eligibility

- The beneficiary is aligned to a participating Next Generation ACO.
- The beneficiary is not residing (at the time of waiver admission) in a SNF or long-term care setting.
  - For purposes of this waiver, independent living facilities and assisted living facilities shall not be deemed long-term care facilities.
- The beneficiary is medically stable.
- The beneficiary has confirmed diagnoses.
- The beneficiary has an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis.
- The beneficiary does not require (further) inpatient hospital evaluation or treatment.
- For direct admission, the beneficiary has been evaluated by a physician or other practitioner licensed to perform an evaluation within 3 days prior to SNF admission

Telehealth Expansion Overview

Current CMS Regulation	NGACO Telehealth Expansion
• Requires an originating site to be in a rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract or a county outside of a MSA.	• Removes this geographic requirement.
• The Beneficiary must be located at an originating site (i.e., where the beneficiary is located when receiving telehealth services) that is a site listed in section 1834(m)(4)(C)(ii) of the Social Security Act	• Allows a Beneficiary's place of residence to serve as an originating site in addition to those listed in section 1834(m)(4)(C)(ii) of the Social Security Act

Telehealth Expansion Overview

- Telehealth services must be provided in accordance with all other applicable state and Federal laws and all other Medicare coverage and payment criteria, including the remaining portions of section 1834(m) of the Social Security Act and 42 C.F.R. §§ 410.78 and 414.65

- Claims will not be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:
  - Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs.
  - Subsequent hospital care services, with the limitation of 1 telehealth visits every 3 days.
  - Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days.

Telehealth Resources

- Medicare Learning Network:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
- Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02):
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04):
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Post-Discharge Home Visit Overview

- Physicians can currently provide services in patients' homes and bill using the applicable Evaluation and Management (E/M) Service code
- This is not a home health (or homebound) service
- Traditionally, this service is provided with direct physician supervision (i.e., physician is present at time service is provided to patient)
- With the NGACO waiver – physician may contract with licensed clinician to provide this service and the service is billed by the physician’s office
- Provides an area of flexibility during this very critical time post-discharge for the patient

Post-Discharge Home Visit Overview (cont.)

- A licensed clinician under the *general supervision* – instead of direct – of a Next Generation Participant or Preferred Provider may bill for "incident to" services at an aligned beneficiary's home.
- Such services may be furnished not more than one time in the first 10 days following discharge from an inpatient facility (hospital, CAH, SNF, IRF) and not more than one time in the subsequent 20 days.
- ACOs are required to abide by their state's laws regarding post-discharge home visits
- Licensed Clinical Staff means auxiliary personnel, as defined in 42 C.F.R. § 410.26(a)(1), licensed or otherwise appropriately certified under applicable state law to perform the services ordered by the supervising physician or other practitioner.

Levels of Supervision

42 CFR § 410.32(b)(3)

- **(i)** *General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
- **(ii)** *Direct supervision* in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
- **(iii)** *Personal supervision* means a physician must be in attendance in the room during the performance of the procedure.

- This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of "general supervision" as outlined in this provision.

Post-Discharge Home Visit Requirements

- A licensed clinician under the general supervision of a physician may bill for home visits to beneficiaries under the following circumstances:
  - The services are furnished to an ACO-aligned beneficiary who does not qualify for home health services. The services are furnished in the beneficiary's home or place of residence during the period after discharge from an inpatient facility.
  - The services are furnished by licensed clinical staff under the *general supervision* of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner), or of the same entity that employs or contracts with the physician (or other practitioner).
  - The billing provider is an ACO Participant or Preferred Provider.
  - The services are furnished by a clinician licensed to perform the supervising provider-ordered services under applicable state law and billed by the provider in accordance with CMS standards.
  - The services are furnished in accordance with all other Medicare coverage and payment criteria.

Post-Discharge Home Visits: When & How

When will this apply?

- When a Participant or Preferred Provider has the post-discharge home visit indicator and is caring for an NGACO aligned beneficiary

How do you bill for this service?

- The claim must contain one of the following E/M HCPCS codes:
  - 99324-99337
  - 99339-99340
  - 99341-99350

Resources

General information about evaluation and management services is available as follows:

- "1995 Documentation Guidelines for Evaluation and Management Services"
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf
- "1997 Documentation Guidelines for Evaluation and Management Services"
  https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf
- "Medicare Benefit Policy Manual" (Pub. 100-02) and the "Medicare Claims Processing Manual" (Pub. 100-04)
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
- International Classification of Diseases, 10th Revision (ICD-10)
  https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html

Beneficiary Coordinated Care Reward

- Each Next Generation Beneficiary automatically eligible.
- $25 reward earned if the Beneficiary received an Annual Wellness Visit from a Next Generation Participant and Preferred Provider in the Performance Year (PY).
- Payment made directly to beneficiaries from CMS.
- No contribution or recoupment from ACOs.

Questions?

Future Open Door Forum Dates

Open Door Forum Topic	Date and Time
Overview of Population Based Payments and All Inclusive Based Payments	April 11, 2017 4:00 - 5:00 PM ET
Deep Dive: Completing Your Next Generation ACO Model Participant List	April 15, 2017 4:00 - 5:00 PM ET

Next Generation ACO Model Webpage:
http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/

E-mail: NextGenerationACOModel@cms.hhs.gov

Technical Support: CMMIForceSupport@cms.hhs.gov