RAVEN

Reduce AVoidable Hospitalizations using Evidence-based interventions for Nursing facilities in Pennsylvania

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Payment Model

AGING INSTITUTE
of UPMC Senior Services and the University of Pittsburgh

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.

Contents

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- ECCP Eligibility
- Facility Payment for Six Qualifying Conditions
- Practitioner Payment #1 – for Six Qualifying Conditions
- Practitioner Payment #2 – For Care Coordination

- **Payment Model Overview**
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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

Payment Model

Existing 2012-2020	New 2016-2020
clinical quality model + new payment mechanism	new payment mechanism
Continuing LTC N=	New LTC N=

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 32.8%	**Urinary tract infection** 14.2%	**Congestive heart failure** 11.6%	**Dehydration** 10.3%	**COPD, asthma** 6.5%	**Skin ulcers, cellulitis** 4.9%

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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.

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Facility Payment for Six Qualifying Conditions

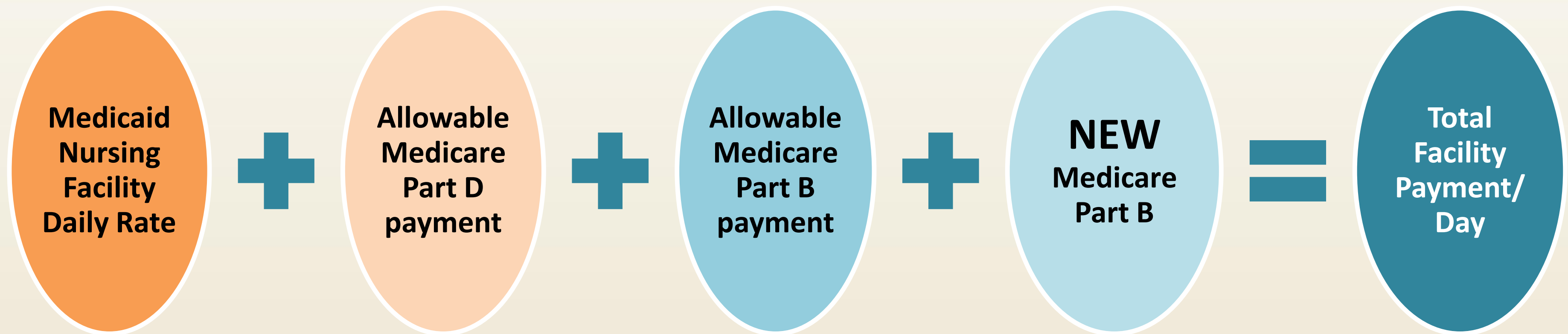
Purpose

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

Payment

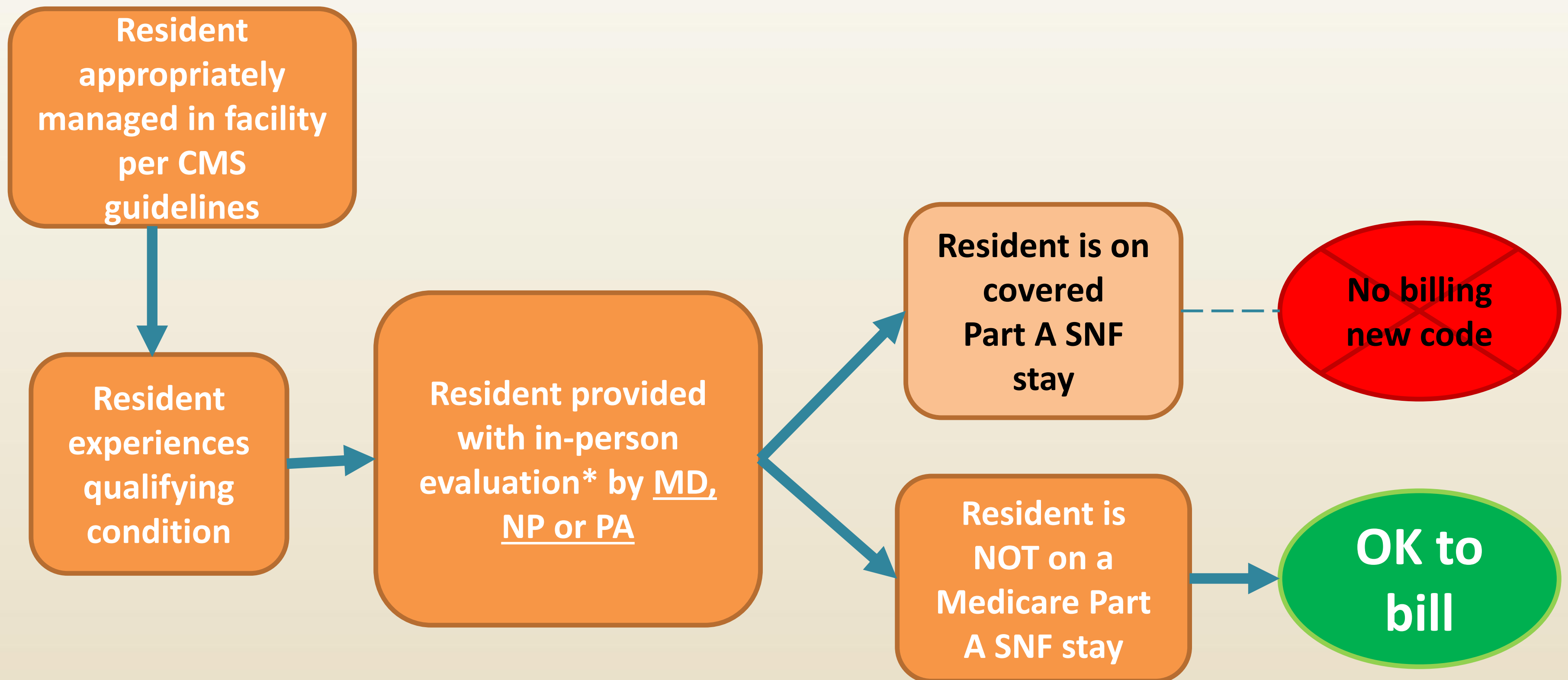
- “Onsite Acute Care”
- Limited to 5-7 days, based on qualifying condition
- Limited to residents **not** on a covered Medicare Part A SNF stay and who meet the long stay criteria

Facility Payment for Six Qualifying Conditions *(cont'd)*



New code added for the participating nursing facilities

Facility Payment for Six Qualifying Conditions *(cont'd)*



* Or qualifying telemedicine assessment

Facility Payment for Six Qualifying Conditions *(cont'd)*

- 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 *(cont'd)*

- Qualifying criteria that could trigger the benefit
  - MD, NP or PA must confirm qualifying diagnosis through in-person evaluation or qualifying telemedicine assessment
  - ANY attending practitioner can provide confirming diagnosis for the purposes of facility payment

Facility Payment for Six Qualifying Conditions *(cont'd)*

- Qualifying criteria that could trigger the benefit (cont'd)
  - Evaluation or assessment must occur by the end of the 2nd day after change in condition
  - Evaluation must be documented in resident's medical record
  - If there is more than one qualifying diagnosis, both should be reported even though facility may only bill code once per day

Facility Payment for Six Qualifying Conditions *(cont'd)*

- Facility may not bill unless diagnosis has been confirmed.
- If treatment begins before official confirmation, facility may bill retroactive to the start of treatment IF confirmation occurs no more than two days afterward.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- Facility must be able to provide the appropriate care for the patient
  - Services must be provided in-house by facility staff or contracted service providers
- Duration of benefit is specific to each of the six conditions.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- 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.

Facility Payment for Six Qualifying Conditions: COPD/Asthma

Qualifying Diagnosis	
THIS	**TWO or more** of THESE
Known diagnosis of COPD/Asthma or CXR showing COPD with hyperinflated lungs and no infiltrates	* 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

Facility Payment for Six Qualifying Conditions: COPD/Asthma

Billing Code

- G9681

Facility Services Required to be Available

- Increased Bronchodilator therapy
- Usually with a nebulizer, IV or oral steroids, or oxygen
- Sometimes with antibiotics

Maximum Benefit Period

- 7 days

Facility Payment for Six Qualifying Conditions: Congestive Heart Failure

Qualifying Diagnosis	
THIS **OR**	**TWO or more** of THESE
Chest x-ray confirmation of a new pulmonary congestion	* 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 worsening edema * New or increased jugulo-venous distension *BNP > 300

Facility Payment for Six Qualifying Conditions: Congestive Heart Failure

Billing Code

- G9680

Facility Services Required to be Available

- 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

Facility Payment for Six Qualifying Conditions: Pneumonia

Qualifying Diagnosis	
THIS **OR**	**TWO or more** of THESE
Chest x-ray confirmation of a new pulmonary infiltrate	* 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 including rales, rhonchi, decreased breathe sounds, or dullness to percussion

Facility Payment for Six Qualifying Conditions: Pneumonia

Billing Code

- G9679

Facility Services Required to be Available

- 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

Facility Payment for Six Qualifying Conditions: Skin Infection

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.

Facility Payment for Six Qualifying Conditions: Skin Infection

Billing Code

- G9682

Facility Services Required to be Available

- 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

Facility Payment for Six Qualifying Conditions: Fluid or Electrolyte Disorder, or Dehydration

Qualifying Diagnosis	
THIS	+ **TWO or more** of THESE
Any acute change in condition	* 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

Facility Payment for Six Qualifying Conditions: Fluid or Electrolyte Disorder, or Dehydration

Billing Code

- G9683

Facility Services Required to be Available

- Parenteral (IV or clysis) fluids
- Lab/diagnostic test coordination and reporting
- 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

Facility Payment for Six Qualifying Conditions: UTI

Qualifying Diagnosis	
THIS	+ ONE or more of THESE
>100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms	* 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

Facility Payment for Six Qualifying Conditions: UTI

Billing Code

- G9684

Facility Services Required to be Available

- 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

Facility Payment for Six Qualifying Conditions *(cont'd)*

- Facility's responsibility to trigger payment code.
- The facility will submit a claim to Medicare just like any other Medicare Part B claim.
- Code may be billed only once a day for a single beneficiary, even if that beneficiary has more than one of the six conditions being treated in the facility.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- The LTC facility may also need to complete a Minimum Data Set (MDS) Assessment for a Significant Change in Condition, following standard MDS requirements (no new MDS requirements for participating facilities).

Facility Payment for Six Qualifying Conditions *(cont'd)*

- The facility may not bill a code on the calendar day during which a resident is discharged, regardless of the time of discharge.
- Separately, CMS will be collecting data on each use of the new billing code as well as other information CMS needs to monitor the Initiative.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- A benefit can be triggered again if beneficiary meets the qualifying criteria for one of the qualifying conditions after the first five to seven days.
- If there is more than one qualifying diagnosis and one has resolved but the other one hasn't or if there is a new qualifying diagnosis, the benefit can be retriggered following a practitioner assessment.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- No requirement for a gap between benefits if condition continues to meet qualifying criteria after the maximum benefit period, but reconfirmation of the diagnosis is required.
- The evaluation must occur no later than the second day after the initial five or seven-day period ends.
- The same rules as for the original qualifying visit would apply.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- If a resident who has been assessed with one of the six conditions is transferred to the hospital for 2 or 3 days for an unrelated condition during the benefit period, a re-evaluation is not needed in order for the facility to continue billing for the eligible condition.
- The benefit period continues from the original assessment.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- For example, consider a resident treated by a facility for Days 1-3, then transferred to the hospital for two days (Days 4-5), returning on Day 6. The facility may bill for Day 6 and Day 7 without a re-evaluation as long as the condition has not yet been resolved.

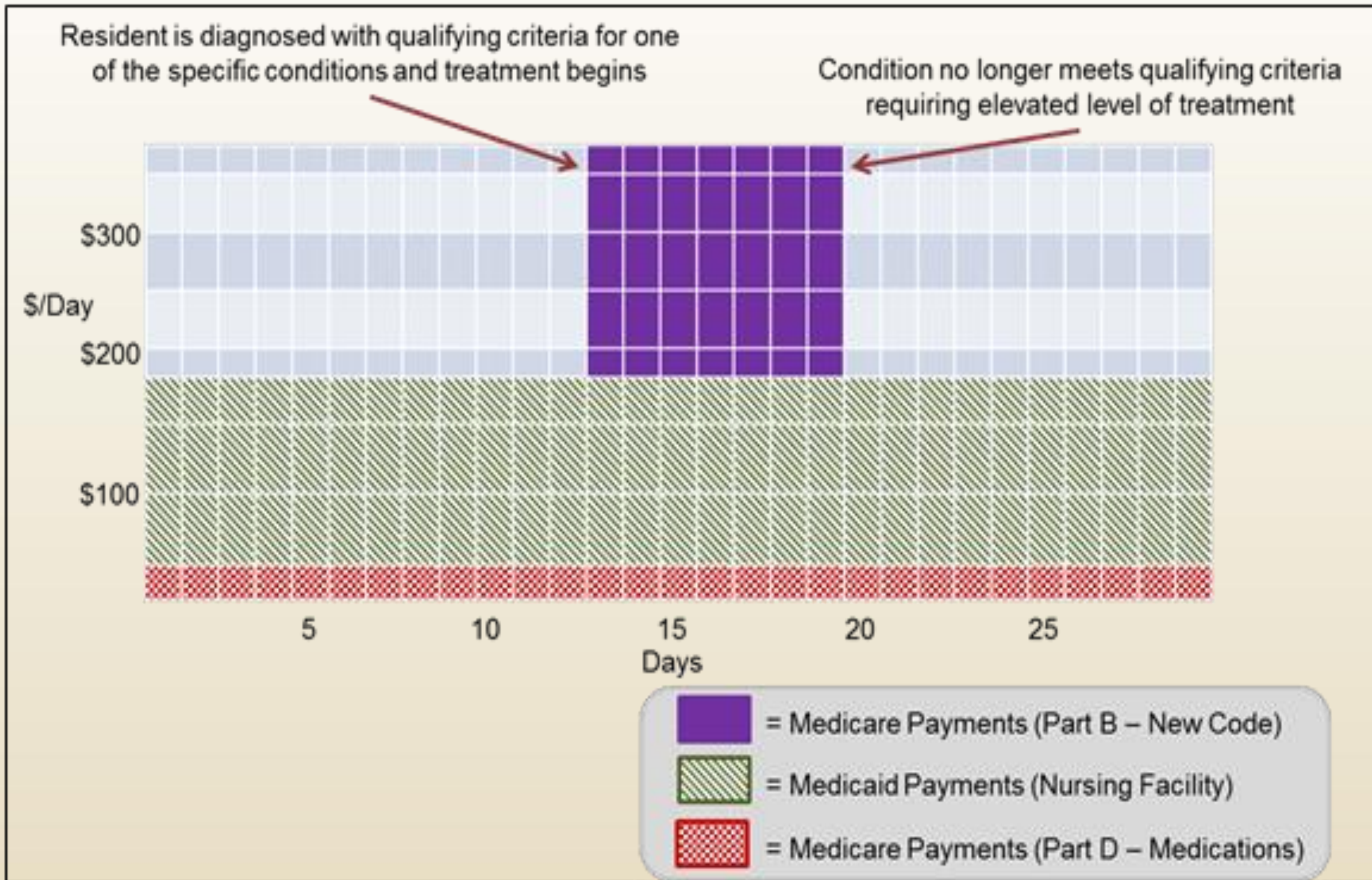
Facility Payment for Six Qualifying Conditions *(cont'd)*

- Day 1 is the day that the change in condition is identified, provided that the practitioner evaluation and confirming diagnosis occurs by the end of the second day following this change (Day 3). If the evaluation occurs later, then the day of evaluation may be treated as Day 1.

Facility Payment for Six Qualifying Conditions *(cont'd)*

- For example, if a resident experienced an acute change in condition on June 1, the evaluation must occur no later than 11:59 pm on June 3 to satisfy Initiative requirements. In that case, facilities may bill the new codes for June 1-3 as appropriate. If the evaluation does not occur until June 4, then the facility would be eligible for payments beginning on that day.

Example of Facility Payment



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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

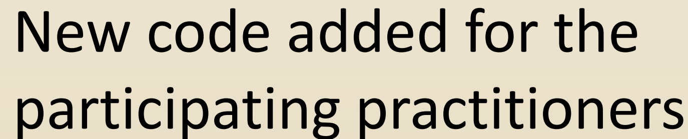
- Billing Code G9685; Acute Nursing Facility Care
- Payment will be equivalent to what would be received for a comparable visit in a hospital.
- Limited to first visit in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed condition)
- NPs &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

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

Current LTC Facility Visit CPT Code 93310

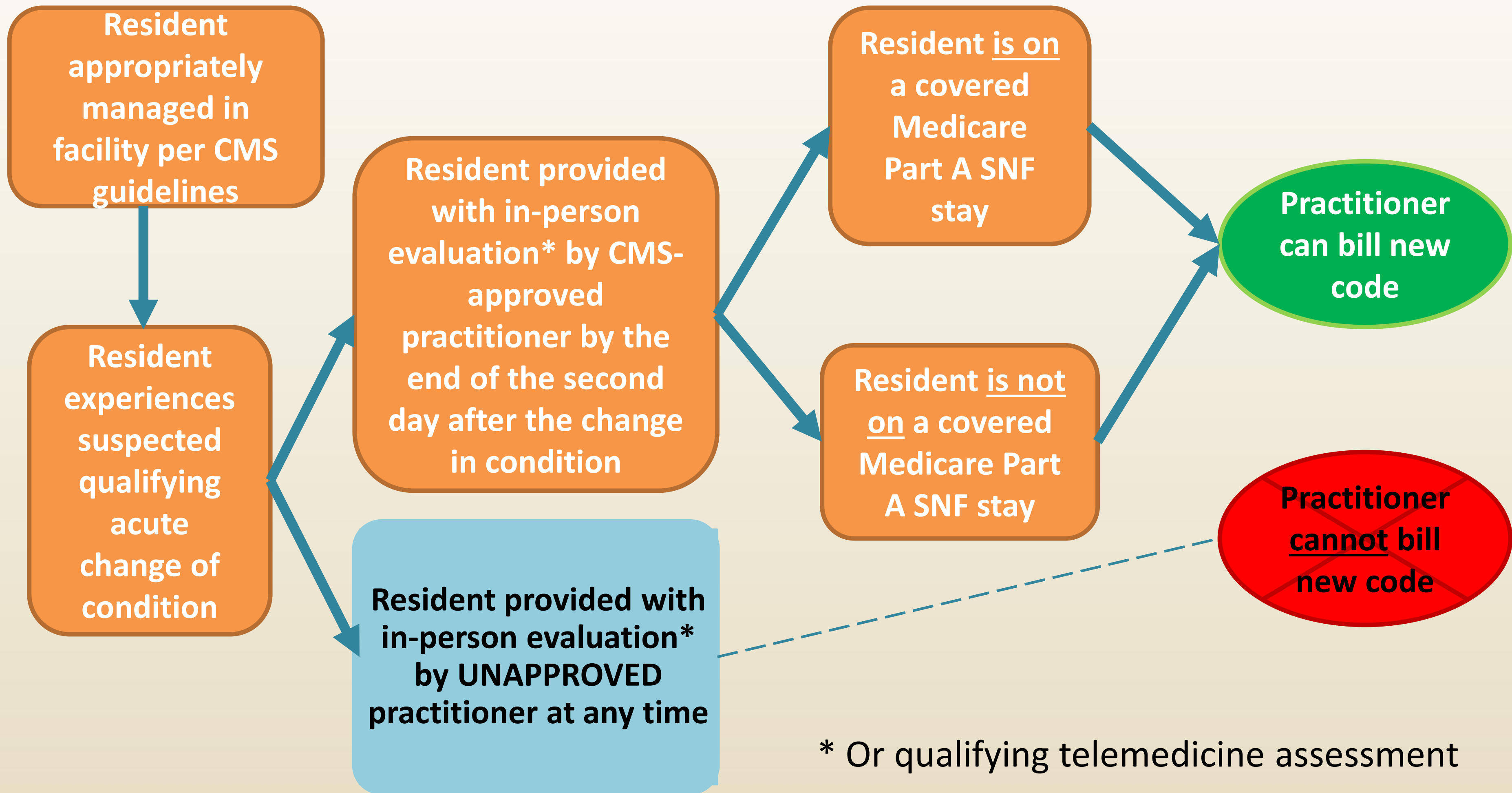
Equivalent Hospital Visit CPT Code 99223

Acute Nursing Facility Care Code G9685



New code added for the participating practitioners

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



* Or qualifying telemedicine assessment

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 or qualifying telemedicine assessment
  - 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.
- If ECCP staff or Telemedicine visit confirms diagnosis to allow facility payment, an eligible practitioner can still see resident for a face-to-face visit by the end of the second day and bill at increased initial visit rate.

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

- Example:
  - ECCP practitioner sees a resident over the weekend via Telemedicine and confirms diagnosis for the facility
  - On Monday morning, the participating provider can assess the resident for the reported change in condition and bill at the increased initial visit rate because the visit occurred within two days of the change in condition.

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.

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- **Practitioner Payment #2 – For Care Coordination**

Practitioner Payment #2 for Care Coordination

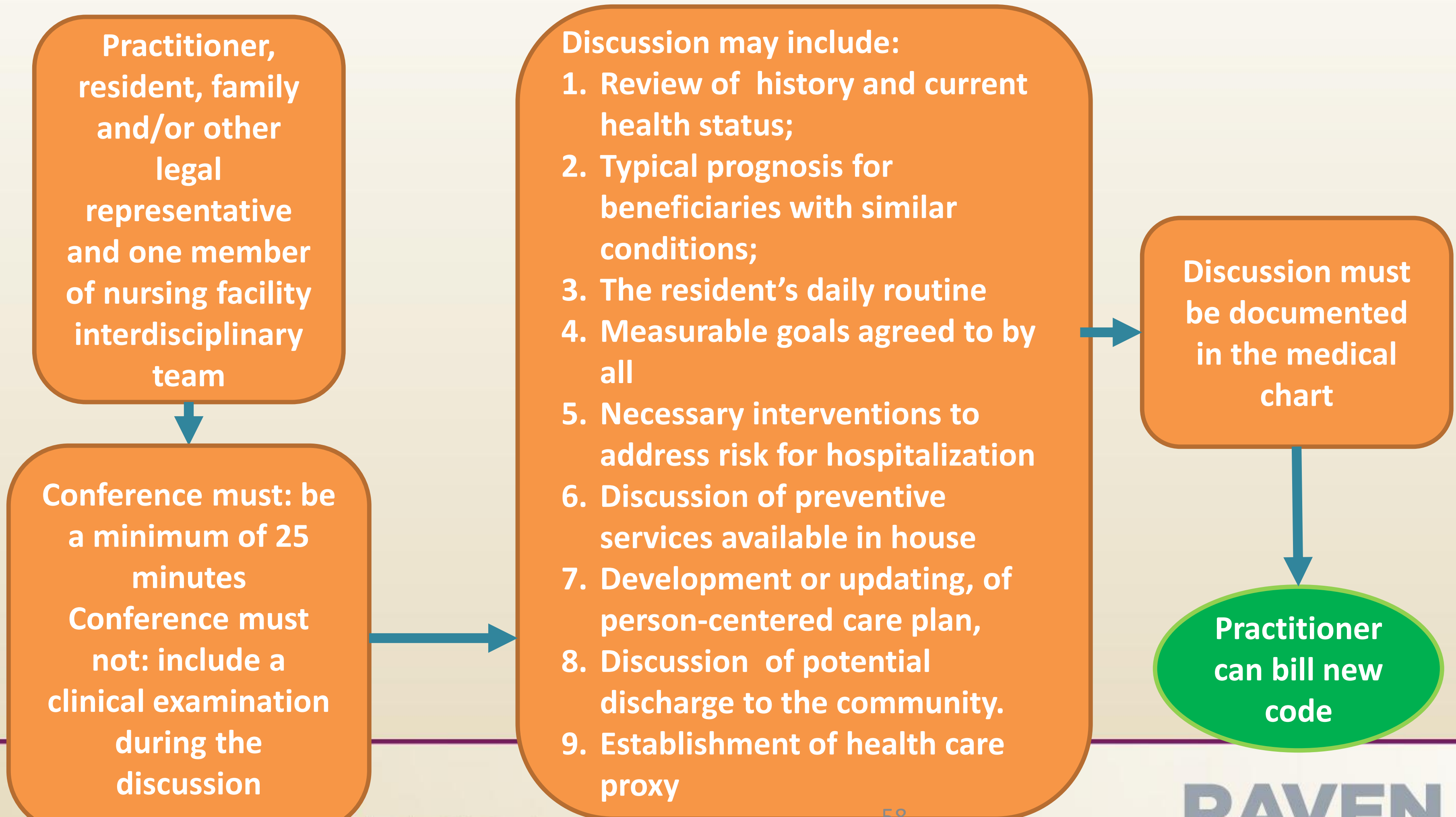
Purpose

- 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.

Billing Issues and Questions

- Please contact your local Medicare Administrative Contractor (MAC) with any questions related to billing, billing statements, or other related questions. Your local MAC can be found by using the following link:

Pennsylvania Jurisdiction L (Novitas):

https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs-A-B-MAC-Jurisdiction-L-JL.html