

# Next Generation ACO Model



**Benefit  
Enhancement**

**April 19, 2016**

# Agenda

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- Coordinated Care Reward
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  - Telehealth
  - Post-Discharge Home Visits
- Open Forum for Questions

# Benefit Enhancement Timeline

Milestone	Date
LOI Due	May 20, 2016
Application Due	May 25, 2016
Next Generation Participant List Due	June 3, 2016
Preferred Provider List Due	Fall 2016
Implementation Plans Due	Fall 2016
Agreements Signed	Late Fall 2016
Start of Performance Year	January 1, 2017

# Eligible Participating Providers

- Next Generation ACOs may be formed by Medicare-enrolled providers and/or suppliers structured as:
  - Physicians or other practitioners in group practice arrangements
  - Networks of individual practices of physicians or other practitioners
  - 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)
  - Critical Access Hospitals (CAHs)
- Any other Medicare-enrolled providers/suppliers may participate in an ACO formed by one or more of the entities listed above.
- ACOs will be required to identify all providers/suppliers participating in the Model.

# Preferred Providers

**Goal:** Contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO and its Next Generation Participants:

- ACO-selected set of partners to contribute to ACO goals
- May offer an ACO's benefit enhancements to aligned beneficiaries
- Services delivered to Next Generation beneficiaries count toward the coordinated care reward calculation
- Preferred Providers will NOT be associated with alignment or used for quality reporting by the ACO

*ACOs are required to identify all providers participating as Preferred Providers*

# Program Overlap

- **With other Medicare models and programs:**

- Participation in other demonstrations or models generally *allowed*;
- Next Generation ACOs *NOT allowed* to simultaneously participate in other Medicare shared savings initiatives (e.g., Medicare Shared Savings Program)
- Next Generation Participating Provider TINs *may not* overlap with Medicare Shared Savings Program TINs.
- Preferred Provider TINs *may* overlap with Medicare Shared Savings Program TINs.

- **Within the Model:**

- Primary care providers may be Participating Providers in only one Next Generation ACO.
- Specialists may be Participating Providers in more than one Next Generation ACO.
- Preferred Providers are not required to be exclusive to any one Next Generation ACO.

# Beneficiary Coordinated Care Reward

- Each Next Generation Beneficiary automatically eligible.
- Reward earned if at least a specified percentage of patient encounters are with Next Generation Participants and Preferred Providers.
- Payment made directly to beneficiaries from CMS.
- No contribution or recoupment from ACOs.

# 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

# 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 who have elected to participate in the waiver
  - Clinical criteria for admission, e.g., beneficiary must be medically stable with confirmed diagnosis of skilled nursing/rehab need.

# Eligibility for SNF or Swing-Bed Hospital or CAH

- Review of SNF, swing-bed hospital, or CAH qualifications to accept direct admissions or admissions after an inpatient stay of fewer than 3 days.
- Review may include program integrity history of the SNF, swing-bed hospital, or CAH.
- At the time of approval any SNF must have a rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website.
- Annual reassessment of SNF, swing-bed hospital, or CAH eligibility.
- CMS retains the right to remove a SNF or swing-bed hospital from the Model for program integrity reasons or for violation of Medicare regulations.

# SNF Beneficiary Eligibility

- The beneficiary is aligned to a participating Next Generation ACO.
- The beneficiary is not residing (at the beginning of the episode) in a SNF or long-term care setting.
- Admission is ordered by a licensed physician or practitioner who is a Next Generation Participant or Preferred Provider.
- The beneficiary is medically stable.
- Confirmed diagnoses by a licensed physician or practitioner.
- The beneficiary has an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis.
- For direct admission, evaluation by a physician or non-physician practitioner within 3 days prior to SNF admission.
- For direct admission, the beneficiary does not require inpatient hospital evaluation or treatment.
- For admission following fewer than 3 days of inpatient hospitalization, the beneficiary does not require further inpatient hospital evaluation or treatment.

# Telehealth Expansion Overview

- Elimination of geographic (rural) component of originating site requirements.
- Beneficiaries may receive telehealth services from place of residence.
- Telehealth services (CPT and HCPCS codes) unchanged.

# Telehealth: Originating Sites

- Geography:
  - 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.
- Facilities:
  - The offices of physicians or practitioners
  - Hospitals
  - Critical Access Hospitals (CAH)
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
  - Skilled Nursing Facilities (SNF)
  - Community Mental Health Centers (CMHC)

# Telehealth Expansion

- Applicable to all telehealth services provided to ACO-aligned beneficiaries by Next Generation Participants or Preferred Providers
- The geographic location of the originating site will not be a component of eligibility for payment.
- Next Generation Participants and Preferred Providers may not submit a claim to CMS when the originating site is a beneficiary's home or place of residence and the service was unable to be provided due to technical issues with telecommunications equipment required for that service.
- 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. HCPCS codes G0406 - G0408.
  - Subsequent hospital care services, with the limitation of 1 telehealth visits every 3 days. CPT codes 99231 - 99233.
  - Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days. CPT codes 99307 - 99310.

# 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>

# What are Post-Discharge Home Visits?

- Physicians can currently furnish 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
- These services can also be billed “incident to” under direct supervision
- With the NGACO waiver a physician may contract with licensed clinician to provide this service under general instead of direct supervision
- Provides an area of flexibility during this very critical time post-discharge for the patient

# Post-Discharge Home Visit Overview

- A licensed clinician under the *general supervision* – instead of direct – of a Next Generation Participating 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.

# Post-Discharge Home Visit Overview

- 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 Participating 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.

# 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 Visits: When & How

## When will this apply?

- When a Participating 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>

# Questions?

## Future Open Door Forum Dates

Open Door Forum Topic	Date and Time
2017 Population Based Payments and All Inclusive Based Payments	April 26, 2016 4:00-5:00 PM ET

Next Generation ACO Model Webpage:

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

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