

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicare-Medicaid Coordination Office

Center for Medicare and Medicaid Innovation

Cooperative Agreement

Supplement – Phase Two

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Applicable Dates:

Funding Opportunity Announcement Released: August 27, 2015

Notice of Intent to Apply: September 9, 2015

Electronic Application Due Date: October 29, 2015, by 5:00 p.m. Eastern Time (Baltimore MD)

Anticipated Notice of Award: January 15, 2016

Anticipated Project Period of Performance: January 15, 2016 to October 23, 2020

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OVERVIEW INFORMATION

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Models, Demonstrations, and Analytics Group

Center for Medicare and Medicaid Innovation

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

The purpose of this funding opportunity announcement (FOA) is to solicit applications to implement a second phase of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (Initiative). Eligible applicants are the current awardees – the Enhanced Care and Coordination Providers (ECCPs).

Under this second phase, the Centers for Medicare & Medicaid Services (CMS) will select eligible ECCPs to partner with long-term care (LTC) facilities and practitioners to implement and test a new payment model with the goal of improving the health and health care among LTC facility residents and ultimately reducing avoidable hospital admissions. Successful applicants will implement the payment model in a manner consistent with the objectives of the Initiative's first phase:

- Reduce the frequency of avoidable hospital admissions and readmissions;
- Improve resident health outcomes;
- Improve the process of transitioning between inpatient hospitals and LTC facilities; and
- Reduce overall health care spending without restricting access to care or choice of providers.

Similar to the first phase, the model shall primarily target long-stay Medicare-Medicaid enrollees in Medicare-Medicaid certified LTC facilities, rather than those likely to experience only a brief post-acute stay and then return home. For the purposes of this Initiative, long-stay residents are limited to those who reside in a LTC facility for 101 days or more.

These activities directly support the CMS Center for Medicare and Medicaid Innovation goals to test models of care that deliver better health care, better health, and reduced costs through improvement. For more information, see [CMS Innovations Website](#).

2. Authority

This FOA is issued under section 1115A of the Social Security Act (added by section 3021 of the Patient Protection and Affordable Care Act (P.L. 111-148), hereinafter referred to as the Affordable Care Act,) which authorizes the Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program while preserving or enhancing the quality of care.

The Affordable Care Act authorized the establishment of the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) to more effectively integrate benefits for individuals eligible for both Medicare and Medicaid. The Medicare-Medicaid Coordination Office is releasing this single source FOA in partnership with the Innovation Center.

3. Background

On March 15, 2012, the Innovation Center and the Medicare-Medicaid Coordination Office (MMCO) announced a solicitation for applications aimed at implementing delivery system interventions that enhance the care, outcomes, and well-being of long-stay LTC facility residents who are enrolled in Medicare and Medicaid. These individuals account for approximately two-thirds of all LTC facility residents nationwide, or approximately 1 million beneficiaries. Several studies have found high rates of preventable hospitalizations among LTC facility residents. For example, a CMS-funded research project included the following key findings for 2005:

- Over 1,000,000 Medicare-Medicaid enrollees in LTC facilities accounted for 690,000 hospitalizations each year.
- Approximately 314,000 (45%) of these hospitalizations were potentially avoidable.
- Combined Medicare and Medicaid costs for avoidable hospital admissions total \$2.7 billion per year, and Medicare costs account for \$2.6 billion of that total.
- The cost of these hospital admissions to Medicare is approximately \$8,000 per avoidable admission.

Through the initial solicitation, CMS selected seven ECCPs that are currently implementing evidence-based interventions in 144 Medicare-Medicaid certified LTC facilities. While each ECCP's intervention has unique features, all include:

- Employing staff who will maintain a physical presence on site at LTC facilities;
- Allowing for participation by LTC facility residents without any need for residents to change providers or enroll in a health plan; and
- Supplementing (rather than replacing) existing care provided by LTC facility staff.

The target population for these interventions is primarily long-stay Medicare-Medicaid enrollees.¹

ECCPs were selected on September 24, 2012, and following a readiness review, began serving beneficiaries in February 2013. The Initiative includes an operations support contractor to ensure readiness and compliance, and an external evaluation contractor to analyze and validate the results and provide rapid feedback to the ECCPs through the program period ([CMS Reduce Avoidable Hospital Admissions Website](#)).

While the first phase of the Initiative established the clinical interventions, it does not address the existing payment policies that may potentially lead to suboptimal care and avoidable hospitalizations. For example, MedPAC has repeatedly reported that it is financially advantageous for LTC facilities to transfer residents to a hospital.² Also, some of the most successful outcomes have been achieved by combining clinical interventions along with alternative payment models. Evercare, an Institutional Special Needs Plan (I-SNP) which started as a Medicare demonstration, was evaluated on the impact of both its clinical and financial models. The final evaluation of this

¹ Long-stay Medicare-Medicaid enrollees are defined as those individuals who have resided in a partnering LTC facility for 101 days or greater or determined to have no active discharge plan as indicated on the MDS assessment section Q 0400A. These individuals must also be enrolled in Medicare A or B, or Medicaid. NOTE: This definition is changing through the implementation of phase two.

² MedPAC June 2010 Report to Congress

program stated that the nurse practitioner's clinical oversight of care, combined with the authorization for additional payment to the LTC facility, can provide the intended outcome for the resident.³ Several other studies have identified other factors that can lead to hospital transfers such as physician preferences and inadequate care planning.

Therefore, a second phase of the Initiative will not only allow us to continue to identify the impact of the clinical interventions, but will also identify the impact of a new payment model, and potentially the impact of both these models combined. The intent of the payment model is to reduce the financial incentive for hospitalization and provide funding for LTC facilities to provide treatment should a beneficiary experience an acute change in condition. The payments would be used by the LTC facility to implement programs and enhance the skills of staff in order to provide a higher level of acute care services in-house, thereby reducing avoidable hospitalizations. The model also includes payment to practitioners (i.e., MD, NP, PA) to equalize the financial incentives that exist between treating beneficiaries in an LTC facility vs. a hospital. There is also an incentive to increase practitioner engagement in care planning activities.

The intent of this phase is to test the payment model in two groups of LTC facilities (with their respective attending practitioners) in the states where the existing ECCPs operate:

- Group A: LTC facilities where an ECCP intervention has NOT been implemented in order to evaluate the impact of the payment model only, and compare to those with the combined models and no model at all.
- Group B: LTC facilities where an ECCP intervention has been implemented through the initial phase of the Initiative (phase one) and will continue to be implemented during phase two in order to evaluate the combined impact of both models. Note: These LTC facilities are subject to a CMS assessment of the ECCP intervention prior to being permitted to participate in phase two.

The proposed model would test the effects of providing payment to skilled nursing facilities (SNFs) and practitioners for the treatment of specific conditions. This model has three components:

1. Payments to a SNF under Medicare Part B for the treatment of qualifying conditions (for beneficiaries not on a covered Medicare Part A SNF stay),
2. Increased practitioner payments under Medicare Part B for the treatment of conditions onsite at the LTC facility,
3. Practitioner payments under Medicare Part B for care coordination and caregiver engagement for beneficiaries in a SNF or NF stay.

Note: The term "practitioner" refers to physicians, nurse practitioners (NPs), and physician assistants (PAs).

Each component is described in detail below.

³ Evaluation of the Evercare Demonstration Program, Final Report, August 2002

1. Payments to a SNF for treatment of qualifying conditions

Research shows that six conditions are linked to approximately 80% of potentially avoidable hospitalizations among LTC facility residents (see Table 1).⁴

Table 1

| 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.

These services can be effectively furnished in an LTC facility with the adequate skills and resources in place. However, LTC facilities commonly transfer beneficiaries to a hospital instead of investing the resources needed to treat these conditions in-house (resulting in avoidable hospitalizations). The Medicare Part A SNF benefit does provide a bundled payment that includes these elevated levels of service when such services are medically necessary; however, a beneficiary must first have a qualifying 3-day inpatient hospital stay (or be readmitted to the SNF level of care within 30 days of a SNF discharge) to access this benefit. Outside of the Medicare Part A SNF benefit, there is limited to no payment or requirement for LTC facilities to furnish the enhanced services needed to treat the above conditions in-house instead of transferring a beneficiary to the hospital. The resulting hospitalizations cost Medicare billions of dollars each year while being detrimental to beneficiaries.

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**. CMS intends to waive 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.

- Onsite Acute Care: \$218 Per Day

⁴ Policy Insight Brief, “Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations”, Segal, September 2011

Payments to a SNF for Onsite Acute Care are subject to ALL of the below criteria:

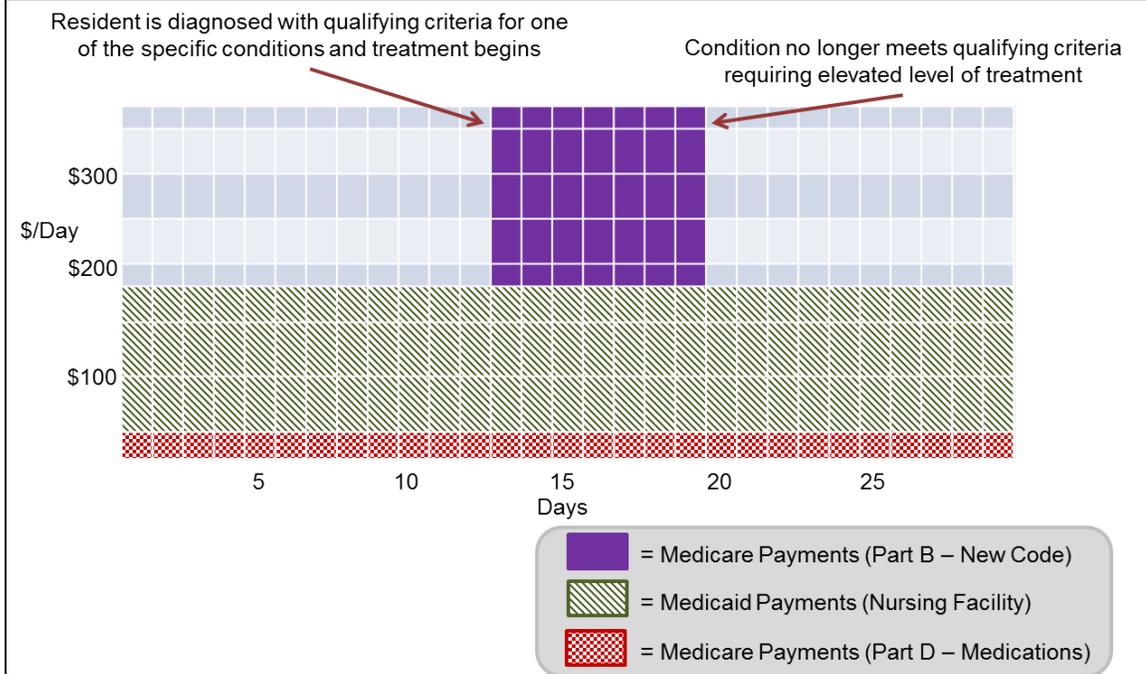
- **Confirmation:** The confirmation of the qualifying diagnosis and the prescription of treatment by the attending practitioner. This confirmation must include an in-person evaluation by a practitioner or a qualifying telemedicine assessment with minimum system requirements as determined by CMS (See Appendix C Guidance for qualifying telemedicine systems and consultations), by the end of the 2nd day after the change in condition. The in-person practitioner evaluation is a separately billable service and not included in the Onsite Acute Care payment. The LTC facility must also complete a Minimum Data Set (MDS) assessment for a significant change in condition (not included in the Onsite Acute Care payment). Note: This visit by the practitioner is not included in the Onsite Acute Care payment. If billed separately by a non-ECCP practitioner (e.g. attending physician) it is billed separately by the practitioner. 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 program). ECCPs shall document the encounter as specified by the CMS program office, including, as practicable and appropriate, the submission of no-pay claims.

- **Qualifying Criteria:** Each of the six conditions has qualifying criteria defining the clinical or diagnostic conditions of a beneficiary that could trigger the benefit. Proposed criteria are detailed for each of the six conditions in Appendix A. For example:
 - Pneumonia Qualifying Diagnosis:
 - Chest x-ray confirmation of a new pulmonary infiltrate
 - OR TWO** or more of the following:
 - Fever >100.4 (oral)
 - Blood Oxygen saturation level < 90% on room air or on usual O2 settings in patients with chronic oxygen requirements.
 - Respiratory rate above 30/minute

- **Duration of Benefit:** As indicated in Appendix A, there is a specific duration of the benefit for each of the six conditions. For example, billing for this Onsite Acute Care for pneumonia is limited to the duration of seven days or through the last day the beneficiary is receiving services in the LTC facility, whichever is shorter (e.g., should the resident be transferred to the hospital on day three, the payment of \$218/day would end on day three). The benefit could be triggered again only if the beneficiary meets the qualifying criteria for pneumonia or another of the qualifying conditions. There is no requirement for a gap between benefits if the qualifying criteria persist after seven days.

For a full description of the qualifying criteria, duration, and treatments for each condition, please see Appendix A – Proposed Nursing Facility Acute Care Benefit Diagnostic Criteria. These criteria will be finalized prior to award.

Example of Component 1 – SNF Payment:



The proposed model would only provide payment to LTC facilities for the specified increased services to treat the conditions, and allow other services to be billed for separately as needed. 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.

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.

In addition to the above, if an LTC facility is coupled with an ECCP intervention, the impact of the payment model would be magnified. For example:

- ECCP RN trainers will enhance the training of quality improvement programs.
- ECCP NPs represent an increased availability of qualified practitioners to be onsite to assess and engage beneficiaries in care planning conferences. (Note: ECCP staff are not permitted to bill Medicare for services provided as a part of this Initiative under phase one or phase two.)
- The presence of other ECCP clinicians (e.g., RN, SW, pharmacy techs) and interventions (e.g., telemedicine) onsite will enable broader and more rapid education and ability to address beneficiaries' needs.

2. Practitioner payments for the treatment of conditions onsite at the LTC facility Evaluation and Management of Beneficiaries (visits)

Practitioners also impact hospitalization rates among LTC facility residents. Several studies have documented factors that lead to a preference for physicians and other practitioners (e.g., NPs) to examine residents in a hospital. Some of these factors include the risk of litigation, the availability of beneficiary information, and payment.⁵ Therefore, we must look past LTC facility payment in order to take a more comprehensive approach to the issue of avoidable hospitalizations.

Currently, practitioners are paid based on the type of visit furnished to a beneficiary. For example, an initial nursing facility care visit typically is paid at a higher amount than a subsequent nursing facility care visit. Additionally, there are different codes and payment rates for services depending on the location of the visit (e.g. hospital vs. nursing facility), the extent of the history and examination, and the complexity of the medical decision making. The existing Medicare fee schedule amounts for subsequent nursing facility visits are significantly lower than those for the initial hospital care visit that would be billed if the beneficiary was transferred to the hospital. For example, a physician could bill \$203 (code 99223) for an initial visit to a beneficiary transferred to the hospital for pneumonia, but could only bill \$136 (99310) to furnish that same visit to a beneficiary in the LTC facility (since they are required to furnish routine visits every 60 days, it only qualifies as a subsequent visit). Yet, based on discussions with physicians with significant expertise in this area, the services furnished during both of these visits are virtually identical. Additionally, the subsequent nursing facility care payments may not adequately address the acuity of significant changes in condition that frequently lead to a beneficiary's transfer.

Therefore, this model tests a new payment under the Medicare physician fee schedule that can be billed by a practitioner for an initial visit to treat an acute change in condition in the LTC facility.

⁵ "Physician Practices in Nursing Homes" (Final Report for ASPE), Levy et. al., April, 2006, and

"Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities", Kaiser Family Foundation, October, 2010

Payment for the service would be based on the condition of the resident rather than whether the service is furnished in a hospital or LTC facility setting. In other words, when a practitioner sees a beneficiary in the LTC facility for an acute change in condition, the practitioner would be paid for the service at the equivalent of an acute hospital initial visit code.

Table 3 shows the proposed Medicare physician fee schedule amount for FY 2016 and the corresponding code. (Note: nurse practitioners and physician assistants are paid at 85% of the physician’s fee schedule amount. Practitioners must comply with existing requirements that distinguish a nurse practitioner’s visit from a physician’s visit.)

Table 3

| LTC Facility Visit CPT Code | LTC Facility Visit Descriptor | LTC Facility Visit Medicare Payment | Equivalent Hospital Visit Equivalent CPT Code | Equivalent Hospital Visit Medicare Payment | Equivalent Hospital Visit New Code | Equivalent Hospital Visit New Descriptor | Equivalent Hospital Visit New Medicare Fee |
|-----------------------------|-------------------------------|-------------------------------------|---|--|------------------------------------|--|--|
| 99310 | Nursing fac care, subseq | \$137.80 | 99223 | \$205.82 | TBD | Acute Nursing Facility Care | \$205.82 |

Acute Nursing Facility Care Descriptor:

Acute Nursing Facility Care, per day, under the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, for the evaluation and management of a beneficiary’s acute change in condition in a nursing facility requiring three key components: A comprehensive review of the beneficiary’s history; a comprehensive examination; and medical decision making of moderate to high complexity. Also includes counseling and/or coordinating care with nursing facility staff and other providers or agencies consistent with the nature of the problem(s) and the beneficiary’s and family’s needs.

This code could only be used for the first visit in an LTC facility in response to a beneficiary who has experienced an acute change in condition (to confirm and treat the diagnosed conditions). Subsequent visits would be billable at current rates using existing codes. In general, the average increase as compared to the existing fee would be approximately \$70. Again, the intent of this payment change is to decrease the financial benefit for a physician to transfer a beneficiary to the hospital, and create an incentive for the physician to visit and treat the beneficiary in the LTC facility, contributing to the reduction of avoidable hospitalizations. Note: ECCP staff are not permitted to bill Medicare for services provided as a part of this Initiative under phase one or phase two.

Note: In conjunction with the visit, the LTC facility should also complete a corresponding MDS assessment for a significant change in condition. Also, a practitioner may bill for the “Acute nursing facility care” service even if the service is furnished because a LTC facility suspects that a beneficiary has one of the six targeted conditions, but upon examination it turns out that the beneficiary does not have such a condition. If we did not permit payment under these circumstances, there could be a disincentive for practitioners to see beneficiaries in the facility until the diagnostics for the qualifying criteria have been confirmed, potentially leading to delays in treatment or avoidable hospital transfers. Finally, this code could also be billed for beneficiaries in the target

population who have Medicaid currently paying for their stay as well as beneficiaries in the target population who are on a covered Medicare Part A SNF stay, and per the requirements listed above.

3. Practitioner payment for care coordination and caregiver engagement

All of the components above (both SNF and practitioner payments) address the need to support increased identification of early signs of changes in condition and treatment of these changes in the LTC facility rather than in the hospital setting. However, neither of the first two components address the need for increased practitioner involvement in person-centered care coordination with beneficiaries and/or engagement with the individual(s) authorized to make health care decisions on their behalf (e.g., caregiver, health care proxy, etc.). This includes improved education by the practitioner on coordination of care for the short and long term scenarios or outcomes the beneficiary might experience as well as consultation with the beneficiary to learn the patient's preferences for his or her care plan. For example, the Agency for Healthcare Research and Quality (AHRQ) has reported that patient preferences are often not known by physicians.⁶

Therefore, the proposed model also includes a payment to create an incentive for practitioners to participate in nursing facility conferences, and engage in care coordination discussions with beneficiaries, their caregivers, and the LTC facility interdisciplinary team about the following:

1. Review of the resident's history of present illness and current health status;
2. Typical outcomes, scenarios, events, or prognosis for beneficiaries with similar conditions;
3. The resident's daily routine (e.g., waking time, eating preferences, other habits, etc.) to help the facility deliver person-centered care;
4. Measurable goals agreed to jointly by the resident, representative(s), caregiver(s), and the interdisciplinary care team;
5. A description of the resident's risk for hospital admission and emergency department visits and all necessary interventions to address the underlying risk factors;
6. Discussion of clinically appropriate preventive services and the facility's capabilities to treat certain conditions in house
7. The development, updating, or confirmation of a person-centered care plan, including if possible an interoperable electronic person centered care plan.
8. Discussion with the resident, family, and/or other legally responsible individual about the resources that would be needed, and the residents ability to potentially be discharged to the community
9. Establishment of a health care proxy where necessary.

In order to bill for this service, the practitioner must conduct the discussion:

⁶ Kass-Bartelmes BL, Hughes R, Rutherford MK. Advance care planning: preferences for care at the end of life. Rockville (MD): Agency for Healthcare Research and Quality; 2003. Research in Action Issue #12. AHRQ Pub No. 03-0018.

- with the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate);
- in a conference for a minimum of 25 minutes;
- without performing a clinical examination of the beneficiary during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion);
- with at least one member of the LTC facility interdisciplinary team; and
- the practitioner must also document the conversation in the beneficiary’s medical chart. This documentation should include information on the above requirements of the conversation. Where possible, the documentation could be created electronically in the LTC facility’s EHR and electronically exchanged with the practitioner and other members of the interdisciplinary team.

The code can be billed only once per year in the absence of a significant change in condition. The code can also be billed within 14 days of a significant change in condition that increases the likelihood of a hospital admission. The change in condition should be documented in the beneficiary’s chart and include an MDS assessment. Note: ECCP staff are not permitted to bill Medicare for services provided as a part of this Initiative under phase one or phase two.

The table below shows the amount for physicians to furnish this activity that would be paid under the Medicare physician fee schedule in FY 2016, and the corresponding code and descriptor (nurse practitioners and physician assistants are reimbursed at 85% of the physician fee schedule amount). As with the first component of the payment model, CMS intends to waive any requirement for a 20% beneficiary coinsurance or payment of a deductible under the model. As with the practitioner payment for acute nursing facility care service, this code could also be billed for beneficiaries in the target population when they are on a covered Medicare Part A SNF stay, as long as the requirements listed above are met.

| G Code | Descriptor | Medicare Fee Schedule (payment) |
|--------|-----------------------------|---------------------------------|
| TBD | Nursing Facility Conference | \$77.64 |

Nursing Facility Conference Descriptor:

Onsite nursing facility conference, separate and distinct from an Evaluation and Management visit, including qualified practitioner and at least one member of the nursing facility interdisciplinary care team under the CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, with a beneficiary and/or caregiver (family or health care proxy) that includes discussion of the beneficiary’s health status and typical outcomes; the beneficiary/caregiver expectations or goals with options to address goals; development, updating, or confirmation of a person-centered care plan; and written documentation of decisions made in the conference. The conference involves a minimum of 25 minutes of practitioner face-to-face time with the beneficiary/caregiver.

4. Program Requirements

LTC facility and practitioner participation will generally be limited to the seven states where ECCPs are currently operating (AL, IN, MO, NE, NV, NY, and PA). In states without enough facilities to

allow recruitment of new facilities for the payment phase and construction of comparison groups of facilities, ECCPs will be allowed to recruit new facilities for phase two in a different state.

For any new states, ECCPs must include a letter(s) from the State Medicaid director and Medicaid survey and certification director expressing support for the application and agreeing to engage in a memorandum of understanding (MOU) upon selection. ECCPs may provide one letter with two signatures or two separate letters. States are permitted to support multiple applicants. In each State where this Initiative is implemented, CMS will solidify the commitments initiated with the letter of support by executing a MOU with the State involved.

ECCPs will retain their role as the “hub” for the Initiative in their respective states and manage the network of LTC facilities and practitioners. CMS reserves the right to approve or terminate any ECCP’s partnering LTC facilities’ and practitioners’ participation in this Initiative (e.g., LTC facility, physician, nurse practitioner) and adjust funding accordingly. Participating LTC facilities, and their respective practitioners, will form the following groups:

- A) **FFS Payment Group:** LTC facilities and practitioners with the PAYMENT MODEL ONLY (no ECCP clinical intervention)
- B) **ECCP + Payment Group:** LTC facilities and practitioners with an ECCP clinical intervention ALREADY IN PLACE and the payment model

NOTE: In general, an ECCP seeking to continue participation in the initiative must apply for both Group A and Group B. CMS may prohibit an ECCP from participating with a particular group. Due to the limited number of LTC facilities in certain of the phase one states, CMS will allow LTC facilities and practitioners to be recruited for Group A from a different state. CMS may prohibit an ECCP from participation in states where there is projected to be substantial enrollment in the Financial Alignment Initiative by eligible beneficiaries in Group B facilities,

Group A - FFS Payment Group: ECCPs will solicit LTC facilities and practitioners for their voluntary participation (similar to their process for the original application to the Initiative). In order to ensure a proper assessment, LTC facilities would need to commit to participation for a minimum of a year and renewable at intervals of one year (termination would be possible for cause). See section 4.3 for required components of the agreement between a LTC facility and ECCP. We would expect this group to be approximately 150 LTC facilities and 16,000 beneficiaries (combined total across all seven states). The intent is for each ECCP to recruit a number of LTC facilities with beneficiaries that is approximately of equal size to the number of LTC facilities and beneficiaries participating with the ECCP through phase one of the Initiative. The anticipated start date for Group A is October 1, 2016 (pending successful passing of screening, vetting, and readiness review). LTC facilities in Group A must be Medicare and Medicaid certified.

Group B – ECCP + Payment Group: The anticipated start date for Group B is October 1, 2016 (pending successful passing of screening, vetting, and readiness review). Those ECCPs approved for Group B shall also be permitted and funded to extend the clinical interventions through September 30, 2020. LTC facilities in Group B must be Medicare and Medicaid certified. Note: Participation is determined at the ECCP level (not LTC facility level). In other words, all LTC

facilities currently participating in Phase 1 (and their attending practitioners) will participate subject to meeting the LTC facility conditions or requirements of participation. There will not be a splitting or subset of partnering LTC facilities within an ECCP's current group.

Eligible Population

The eligible beneficiary population for this Initiative (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 the LTC facility
- 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 managed care plan (e.g., Medicare Advantage)

NOTE: The first phase of the Initiative also included beneficiaries who had not resided in the LTC facility for 101 days or more, but had "no active discharge plan" as indicated in the MDS assessment section Q0400A ("MDS qualifier"). Through this phase of the Initiative, the MDS qualifier will no longer be applied and only those beneficiaries who have resided in the LTC facility for 101 days or more shall be considered long-stay for the purposes of this Initiative. CMS will select a "phase out date" at which time beneficiaries who were previously identified as eligible through the MDS qualifier may continue to be eligible for the Initiative, but newly eligible beneficiaries will no longer be identified through the MDS qualifier. Additionally, the first phase allowed ECCPs to include long-stay beneficiaries who were enrolled in Medicaid or received benefits from the Veterans Administration, but were not enrolled in Medicare. Those beneficiaries are still eligible for the ECCP interventions available through phase one, but are not eligible for the Medicare benefits to be tested through the second phase of the Initiative.

Waivers

The authority for this Initiative is section 1115A of the Social Security Act (SSA). Under section 1115A(d)(1) of the SSA, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). For this Initiative and consistent with the standard in section 1115A(d)(1), the Secretary is considering issuing waivers of certain payment policies. The Secretary currently has no plans to issue any waivers of the fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the SSA for this model. Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this Funding Opportunity Announcement, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the Initiative. Any such waiver would apply solely to the Initiative and could differ in scope or design from waivers granted for other programs or models.

CMS intends to waive the following requirements in order to make the new payments under phase 2 of the Initiative from the Part B trust fund:

1) Payments to a SNF for treatment of the six qualifying conditions:

- Section 1861(s)(2)(B)) (locational requirements)

2) Practitioner Payments for (a) the treatment of conditions onsite at the SNF and (b) care coordination and caregiver engagement:

- Section 1848(a)(1) (payment for physicians' services under the Physician Fee Schedule)
- Section 1833(a)(1)(N) (payment at 80% - implicit copayment)
- Section 1833(b) (Part B deductible)

Program Safeguards

As the second phase of this Initiative is developed, CMS may incorporate a variety of program integrity or other safeguards to ensure that the model does not result in program or patient abuse.

4.1 Coordination for Participation of LTC Facilities and Practitioners in Group A

The ECCP shall propose a cohort of LTC facilities (not including facilities participating in Phase 1) and practitioners to form Group A for this phase of the Initiative. This cohort should be approximately the same size as the number of LTC facilities and beneficiaries participating in the first phase of the Initiative. Additionally, LTC facilities and practitioners **MUST** meet the criteria below in order to participate with phase two of the initiative. 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 or practitioner's participation in the Initiative.

LTC Facility Eligibility

In order to be eligible to apply, LTC facilities must meet the following criteria:

Regulatory and Demographic Criteria:

- Not be on the CMS list of Special Focus Facilities;
- For participation in Group A, have no survey deficiencies for immediate jeopardy to resident health or safety within the last 12 months;
- Not have 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;
- For participation in Group A, have an average daily census of greater than 80 residents with greater than 40% of the total LTC facility census as long-stay⁷ Medicare enrollees in traditional FFS Medicare (not enrolled in Medicare Advantage); and
- For participation in Group A, have at least a three star overall rating on Nursing Home Compare on the date of this Funding Opportunity Announcement.
- For participation in Group A, ECCPs shall give preference to recruiting LTC facilities that use technology to support clinical care and interoperable health information exchange (for example use technology that supports the creation and exchange of electronic care plans⁸, transformation of assessment data into interoperable assessment summaries⁹, and creation and exchange of interoperable transition of care summary documents¹⁰).

⁷ Long-stay residents are defined as beneficiaries who have resided in the LTC facility for 101 days or more.

⁸ A LTC facility could use an EHR that embeds the C-CDAR2 Care Plan standard

⁹ A LTC facility could enter into an agreement with the KeyHIE to (i) transform electronic MDS assessments into an interoperable LTC assessment summary document (using the CCD standard) and (ii) transmit the assessment summary document to an authorized recipient (e.g., hospital, physician, etc.)

¹⁰ A LTC facility could use technology that has been certified to the ONC transition of care certification criteria.

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 Appendix B of the FOA for the required elements of a tool. Note: Separate from this, LTC facilities will need to complete the MDS assessment for beneficiaries experiencing a significant change in condition.
- 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.

LTC facilities will be required to provide evidence that all of the readiness review criteria have been met. They will also need to submit a letter of intent and/or execute a participation agreement with the ECCP as described in section 4.3. This will be verified through a combination of interviews, site visits, and documentation to be submitted by the facility.

In order for practitioners (i.e., MD, NP, PA) to participate, they must follow the below criteria:

Regulatory and Demographic Criteria:

- Have carried an average panel (daily census of beneficiaries) of at least seven long-stay FFS Medicare beneficiaries in the affiliated participating LTC facility over the most recent six months;
- Have all licensure and certification in good standing;
- Not have had any sanctions, indictments, probations, corrective action plans, or judgments imposed in the last three years relating to fraudulent or abusive billing practices; and
- Not be excluded from participation in the Medicare or Medicaid programs.
- ECCPs shall give preference to recruiting practitioners that use technology to support interoperable health information exchange (for example use technology that supports the creation and exchange of electronic care plans and creation and exchange of interoperable transition of care summary documents).

Practitioners will need to attest they meet these requirements and that they will adhere to the conditions of the Initiative. See 4.3 below for required components of practitioner attestation.

LTC facilities and practitioners will be screened to determine eligibility for further review using the above criteria and applicable law, including 2 CFR Parts 180 and 376. In addition, CMS may deny model participation to an otherwise qualified LTC facility or practitioner on the basis of information found during a program integrity review regarding the applicant, its affiliates, or any other relevant individuals or entities. LTC facilities and practitioners will be required to disclose any sanctions, indictments, probations or corrective action plans, or judgments that have been imposed on them in the last three years.

4.2 Coordination for Participation of LTC Facilities and Practitioners in Group B

ECCPs will need to submit the same information for the LTC facilities and practitioners in Group B as is required for those in Group A above. Since these LTC facilities have already been identified through the first phase of the Initiative, a reduced amount of effort is expected. However, with the exception of certain regulatory and demographic criteria, the same qualifying criteria listed above also apply to Group B and ECCPs will need to submit the same required information (Letter of Intent, Attachment A – Draft LTC Facility Submission Grid and Attachment C – Draft Practitioner Submission Grid). Note: Executed agreements (or amended agreements) with ECCPs for this phase of the Initiative may be submitted in lieu of a Letter of Intent (signed agreements are preferred).

Practitioners will need to attest they meet the requirements for participation and that they will adhere to the conditions of the Initiative. See section 4.3 for required components of practitioner attestation.

Note: The LTC facilities participating in group B through the first phase of the Initiative shall not change, except to the extent currently participating facilities fail to meet the conditions or requirements of participation for phase two (ECCPs are not permitted to change this group as a result of phase two). In other words, all current LTC facilities (and their attending practitioners) will participate subject to meeting the conditions and requirements of participation. There will not be a splitting or subset of partnering LTC facilities within an ECCP's current group. LTC facility participation remains voluntary, however eligible LTC facilities and practitioners opting to participate in phase two must commit to participate for a minimum of a year (renewable at intervals of one year).

4.3 Requirements for Letter of Intent and Agreements for Participation

LTC Facility Letter of Intent

LTC facilities must submit a letter of intent to participate. The submission of a letter of intent or signed agreement for participation does not guarantee participation in the Initiative. CMS will ultimately approve the LTC facilities and practitioners that participate after reviewing applicants' qualifications. This letter or other documentation should clearly state that if the LTC facility or practitioner were selected and approved for participation, they would adhere or attest to the following (at a minimum):

- An attestation that the LTC facility meets all of the regulatory and demographic criteria listed above.
- A statement indicating the provider's intent to participate through the end of the Initiative (through September 2020).
- A statement agreeing to adhere to the requirements and qualifying criteria to receive payment under this Initiative. For example, ensure the diagnostic criteria listed in Appendix A exist prior to billing CMS for the new payment.
- A statement agreeing to participate with the learning community for the Initiative (e.g., attend events, webinars, etc.).
- A statement agreeing to respond to requests from CMS or its contractors for the purposes 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 (e.g., phone or internet).
- A statement committing to make the best available decisions for care for beneficiaries at all times regardless of payments received through the Initiative. There shall be no withholding of care or services in lieu of payments. As with the facility's policy and procedures requirement, the letter of intent must describe the facility's commitment to transfer a beneficiary to the hospital when appropriate (e.g., when the beneficiary cannot be safely treated in the facility, upon the physician's orders, or at the beneficiary's or health care proxy's discretion).
- (For LTC facilities and practitioners already partnering with ECCPs through phase one of the Initiative) A statement committing to continue to partner with the ECCP on all relevant aspects of the clinical interventions. This includes regular communication, coordinating care, adhering to previous commitments or agreements, or any other activities that are part of the original ECCP's interventions' design.

- The average daily census and an estimated average daily number of beneficiaries that meet the criteria of the target population, along with a statement agreeing to apply the payment model under this Initiative exclusively to the target population.
- A statement indicating the intent to meet the required prevention and treatment criteria above in order to pass the readiness review, and to maintain these criteria through the end of the initiative.
- A commitment to collaborate with the ECCP to help coordinate, recruit, and screen the practitioners that are affiliated with the facility to participate and help meet the goals of the Initiative.
- A statement indicating the intent to execute a participation agreement with the ECCP as a partner under this Initiative, prior to passing the readiness review and receiving payment under this Initiative.
- A commitment to promptly communicate any changes in the LTC facility's information to the ECCP and CMS or its contractors (e.g., change of ownership, TIN, NPI, CCN, etc.).

Participation Agreement:

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 above criteria through the end of the Initiative (we note that a facility's ability to meet the demographic criteria of an average daily census of greater than 80 residents with greater than 40% of the total LTC facility census as long-stay Medicare enrollees in traditional FFS Medicare, may be outside of the facility's control and may fluctuate throughout the period of performance. CMS will address these fluctuations on a case by case basis).

Executed agreements between LTC facilities and ECCPs for this phase of the Initiative may be submitted in lieu of a Letter of Intent (executed agreements preferred). For LTC facilities partnering with ECCPs for phase one of the Initiative, agreements for phase two should not supersede the existing agreements for phase one. Rather, these new agreements should supplement what has already been agreed upon. As such, ECCPs and existing partners may choose to create new agreements addressing the needs for both phases, or amend current agreements with the requirements for phase two of the Initiative. These agreements should include all of the above items (as appropriate) and also include the following information:

- Termination language allowing for an LTC facility to opt out of the Initiative with adequate notice (minimum 30 days prior to the end of a budget period) to all parties to avoid any gaps in care. Note: LTC facilities may only opt out of the Initiative at yearly intervals based on the budget period.
- A commitment to collect and share data and information, in compliance with applicable privacy requirements, necessary for the operations of the Initiative and the care of beneficiaries (e.g., eligibility information).
- A commitment to identify and maintain a primary and secondary contact for all matters related to the Initiative.

Practitioner Letter of Intent:

As part of the application process, practitioners must submit a letter of intent to participate. CMS is open to exploring methods that reduce the burden associated with collecting and submitting practitioner letters of intent, while still ensuring practitioners fully understand and meet the criteria

for participation. CMS will ultimately approve the practitioners that participate after reviewing their qualifications. The letter of intent should clearly state that if the practitioner were selected and approved for participation, he/she would adhere or attest to the following (at a minimum):

- a) An attestation that the practitioner meets all the regulatory and demographic criteria stated above.
- b) A statement agreeing to adhere to the requirements and qualifying criteria to receive payment under this Initiative.
- c) A statement agreeing to participate with the learning community for the Initiative (e.g., attend events, webinars, etc.).
- d) A statement agreeing to respond to requests from CMS or its contractors for the purposes 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 (e.g., phone or internet).
- e) A statement committing to make the best available decisions for care for beneficiaries at all times regardless of payments received through the Initiative. There shall be no withholding of care or services in lieu of payments
- f) (For practitioners already partnering with ECCPs through phase one of the Initiative) A statement committing to continue to partner with the ECCP on all relevant aspects of the clinical interventions. This includes regular communication, coordinating care, adhering to previous commitments or agreements, or any other activities that are part of the original ECCP's interventions' design.
- g) The practitioners average panel (daily census of beneficiaries) of long-stay FFS Medicare beneficiaries in the corresponding participating LTC facility over the most recent six months.
- h) A statement agreeing to apply the payment model under this Initiative exclusively to the target population.
- i) A statement of the practitioner's commitment to meeting and maintaining the above criteria through the end of the Initiative (we note that a practitioner's ability to meet the demographic criteria of an average panel of seven residents in the target population over the most recent six months may be outside of the practitioner's control and may fluctuate throughout the period of performance. CMS will address these fluctuations on a case by case basis).
- j) A statement regarding whether the practitioner uses an ONC-certified EHR and whether the practitioner uses health IT for care planning or the creation and exchange of transition of care documents.
- k) A commitment to promptly communicate any changes in the practitioner's information to the ECCP and CMS or its contractors (e.g., change of ownership, TIN, NPI, CCN, etc.).

Note: Regardless of LTC facility or practitioner participation, beneficiaries enrolled in a Medicare managed care plan (e.g., Medicare Advantage (MA), Institutional Special Needs Plan (I-SNP)), beneficiaries not enrolled in Medicare, or beneficiaries residing in a bed that is not Medicare or Medicaid certified are excluded from this phase of the model. CMS prefers the inclusion of LTC facilities with high rates of beneficiaries in the target population and LTC facilities and practitioners with high rates of avoidable hospitalizations for the six target conditions.

In addition, LTC facilities and practitioners will be screened to determine eligibility for further review using the above criteria and applicable law, including 2 CFR Parts 180 and 376. In addition, CMS may deny model participation to an otherwise qualified LTC facility or practitioner on the basis of information found during a program integrity review regarding the applicant, its affiliates, or any other relevant individuals or entities. LTC facilities and practitioners will be required to disclose any sanctions, indictments, probations or corrective action plans, or judgments that have been imposed on them in the last three years.

Prior to allowing LTC facilities and practitioners to participate with this phase of the Initiative, CMS will conduct a program integrity screening to ensure each participant is in good standing with all applicable qualification criteria. We will also perform an analysis of other demonstrations and initiatives to ensure there is no overlap that could impact the effect of the model, the evaluation of this Initiative, or result in duplicative payments or services. We may reject an application if we determine that the applicant's participation in another demonstration or initiative would cause such overlap or results. Routine checks will also be performed to monitor for any overlap or other program integrity risks throughout the period of performance.

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.

4.4 Enhanced Care and Coordination Provider Activities: For the work described in this FOA, selected ECCPs will need to continue the activities authorized under the current cooperative agreement and to engage in the following activities as well (an ECCP may have activities limited to a particular group based on direction from CMS):

a) Kick-off Teleconference

Within 10 calendar days of the phase two award date, each ECCP shall participate in a kick-off teleconference with CMS. This teleconference provides the opportunity to discuss the project tasks, deliverables, schedule, lines of communication, role of each team, and any other elements required for an efficient project launch.

b) Work Plan

Within 15 calendar days of the phase two award date, each ECCP shall begin to execute the work plan as submitted and approved for this FOA. There will be a separate work plan for Group A and Group B. Each work plan will identify key milestones, tasks, interdependencies, and the responsible parties for each, as well as a related timeline. Each work plan should contain, at a minimum, target dates for the following:

- In consultation with CMS, finalizing a list of LTC facilities to target for recruitment for Group A (this list should be large enough to form an adequate pool of prospective LTC facilities from which to screen and propose a final list of Group A LTC facilities to CMS). Confirming a primary and secondary contact at each prospective participating LTC facility.
- Educating the targeted list of LTC facilities on all aspects of the Initiative
- Educating and finalizing the list of respective practitioners at each LTC facility for both groups (can be different target dates for each group).

- Completion of the recruitment of prospective LTC facilities for Group A.
- Completion of screening of practitioners to confirm eligibility to participate and for final submission to CMS (for both groups).
- Completion of the screening and prioritization of the list of LTC facilities to propose and submit to CMS for Group A.
- For both groups, assessing LTC facilities' current status as compared to the readiness review requirements (can be different target dates for each group). This will be tracked using a Readiness Review Tracker (see Appendix D for sample template).
- For both groups, completion of requirements in order to pass the readiness review.
- For Group B, a plan to implement any changes to the clinical intervention necessary to address any challenges identified to date, improve performance and to better coordinate the clinical intervention with the introduction of facility and practitioner payments.
- Obtaining executed agreements for participation from each partnering LTC facility.

Target dates proposed should align with the deliverables described in this FOA. However, ECCPs may choose to propose earlier dates (e.g., obtain primary and secondary contacts for LTC facilities prior to the submission of an application for this FOA). The work plan will be reviewed regularly, as frequently as bi-weekly, and updated and provided to CMS, as needed. CMS may also share it with the State Medicaid agency and State survey and certification agency.

c) Continued Recruitment and Education of Prospective Participating Providers

Each ECCP will work to identify a set of interested LTC facilities and practitioners for Group A and Group B. The actions taken in this activity will be based on the approved plan as submitted through application to this FOA. This should include the methods and process for educating prospective participants on the details of the Initiative. Applications should include any resources for identifying and communicating with LTC facilities and practitioners such as key stakeholders (e.g., associations, state agencies, etc.), the types of venues to be used to convene recruitment and educational sessions, and the process for collecting and responding to requests or questions from providers or stakeholders. There will be a separate plan for Group A and Group B (some overlap in activities is expected) with adjustments made as appropriate (e.g., a search for potential LTC facilities for Group B is not needed since those providers are already known). A draft list of prospective LTC facilities and practitioners should be submitted with the application for this FOA and should include more LTC facilities than needed for Group A (See Attachment A - Draft LTC Facility Submission Grid and Attachment C – Draft Practitioner Submission Grid). A final list of prospective LTC facilities and practitioners should be completed within 60 days after the phase two award date (the list does not need to be submitted to CMS at this time).

Note: CMS intends to take actions to promote awareness and education about this phase of the Initiative amongst providers after the release of this FOA to aid ECCPs with recruitment and education.

d) Screening of Prospective Participating Providers

Upon identifying a set of interested LTC facilities and practitioners, ECCPs will need to screen all providers to recommend the most appropriate set of LTC facilities and practitioners to participate with this phase of the Initiative. In addition to assessing all of the qualifying criteria

listed in 4.1, ECCPs should also collect, assess, and provide the following information to CMS at minimum and as available: Bed size, LTC facility ownership (for profit or not for profit), chain affiliation or independently owned, number of attending practitioners that meet the practitioner eligibility requirements, confirmation of execution agreement for the terms and conditions of the Initiative, hospitalization and/or potentially avoidable hospitalization rates, payer source or case mix, and other pertinent beneficiary, LTC facility, or practitioner information (to be submitted on or in conjunction with Attachment A – Draft LTC Facility Submission Grid). For Group A, the ECCP should also take actions to identify a group of LTC facilities very similar to its existing group of partnering LTC facilities. A draft list of prospective LTC facilities should be submitted with the application for this FOA and should include more providers than needed (See Attachment A - Draft LTC Facility Submission Grid). CMS prefers for ECCPs to prioritize the list of LTC facilities in order of most recommended to least and to identify preferred alternative LTC facilities should any of the recommended LTC facilities not be able to participate. After an ECCP has developed its final list of prospective LTC facilities for groups A and B, the ECCP should then screen these providers to create the final list of proposed participating LTC facilities to submit to CMS. In addition to recruiting and educating, ECCPs shall also screen practitioners for participation with this phase, and submit the practitioners associated with the proposed LTC facilities to CMS (see Attachment C – Draft Practitioner Submission Grid). These lists should be submitted within 90 days after the phase two award date. CMS will ultimately select the LTC facilities and practitioners that participate.

e) Technical Assistance and Readiness Review

ECCPs shall work with their approved partnering LTC facilities and practitioners to complete the activities required to successfully pass the readiness review and begin receiving payments for services under this phase of the Initiative. The readiness review requirements for groups A and B are described in section 4.1 above.

ECCPs and LTC facilities and practitioners may be required to submit more detailed information than listed above prior to receiving approval. For example, additional information on the capabilities or availability of an external company to start IVs, information about an external consultant to read EKGs, copies of a structured tool to document and communicate a resident's change in condition, and other such details may be required. LTC facilities will need to provide evidence and documentation to meet all requirements of the readiness review (LTC facilities do not, however, need to be conducting all of the activities above at the time of application). CMS will provide a final list of the readiness review requirements to those ECCPs that are awarded funds for phase two under this FOA. The ECCP shall work with its partnering LTC facilities to meet the readiness review requirement and all information will be submitted to the operations support contractor. LTC facilities and practitioners may also need to participate in phone calls with the operations support contractor to review the components of phase two of the model and ensure all requirements of the readiness review have been met. LTC facilities and practitioners will be vetted consistent with policies for participation with other CMS models and demonstrations and some LTC facilities may also be selected for an in-person site visit.

Within 60 days of CMS approval of Groups A and B, ECCPs must submit a Readiness Review Tracker (Appendix D) that includes a timeline for each LTC facility must successfully pass the readiness review by September 1, 2016.

Throughout the model period, the ECCP shall also provide technical assistance and education to partnering LTC facilities and practitioners on the payment model as needed and in conjunction with the operations support contractor and CMS.

f) Reporting

Some reporting requirements of the first phase of the Initiative remain (tasks 3.d Quarterly, 3.e Semi-Annual Funding, and 3.f Final Report) which will be decided upon prior to the start of phase two. CMS will alter required elements to obtain information necessary for the monitoring, evaluation and ECCP quality improvement efforts for phase two of the Initiative and reduce the burden of data collection and reporting.

g) Participation in CMS Learning Community

The ECCP will continue to be required to participate in the activities of the CMS Learning Community developed to support this Initiative. These activities include periodic web-based teleconferences, topic-specific webinars and calls, and active sharing of information and learning among partnering entities, including the opportunity for site visits to organizations showing early success, and annual in-person meetings with CMS and other ECCPs. Through phase two, each ECCP should create and manage a localized learning community where best practices, lessons learned, successes, challenges, and other pertinent topics can be shared and leveraged to improve outcomes among each group of providers.

| Activity- Note: The deliverables in phase two will be in addition to the deliverables required in the first phase of the Initiative (e.g., reports) per the original FOA and cooperative agreements. | Due Date |
|---|---|
| Kick-off Teleconference | Within 10 calendar days of phase two award date |
| Work Plan | Completed within 15 calendar days of phase two award date |
| Recruitment and Education of Prospective Participating LTC facilities and practitioners | Completed within 60 calendar days of phase two award date. |
| Screening of Prospective Participating LTC facilities and practitioners | Completed and submitted to CMS within 90 calendar days of phase two award date. |
| Technical Assistance and Readiness Review | Submission of Readiness Review Tracker, including timeline for successful completion of readiness review, within 60 days of CMS approval of Groups A and B. Successful completion of Readiness Review by September 1, 2016. |
| Anticipated Start and End Date for New Payments for Group A | October 1, 2016 – September 30, 2020 |
| Anticipated Start and End Date for New Payments for Group B | October 1, 2016 – September 30, 2020 |

4.5 Schedule of Deliverables

4.6 Payment and Restriction on Billing

ECCPs shall be eligible to receive funds from the Payment Management System for each group of LTC facilities and for the extension of the clinical intervention. ECCPs are eligible to receive funds for Group A and Group B and the extension of the clinical intervention upon receipt of award for phase two under this FOA. CMS may limit funding for only those groups with whom an ECCP has been approved to participate.

See II. 1. Award Information, Total Funding below.

ECCP staff (e.g. nurse practitioners) are not eligible to bill CMS for any of the codes or payments being tested under phase two. Similarly, all billing restrictions established through the first phase of the Initiative remain. For example, ECCP nurse practitioners cannot also bill Medicare or Medicaid for services rendered to LTC facility residents at the LTC facilities participating in this Initiative. If practicable, CMS may provide for the submission of no-pay billing codes by ECCP practitioners to document provision of care.

SNFs and practitioners partnering with ECCPs under this Initiative may only bill the codes associated with the payment model to be tested for services provided to beneficiaries that meet the eligibility criteria under this FOA (target population). SNFs and practitioners may NOT bill the codes associated with the payment model for services provided to any beneficiary that does not meet the eligibility criteria under this FOA, and CMS will monitor this throughout the Initiative. SNFs and practitioners that engage in improper billing may be terminated from the model or required to implement a corrective action plan approved by the program office. CMS reserves the right to recoup funds from SNFs and practitioners who receive payment as a result of improper billing. CMS reserves the right to alter funding to ECCPs for activities at any LTC facility where there is a material change in total occupancy, payer mix, or other changes that would fundamentally change the scope of the Initiative. CMS also reserves the right to change disbursement methods. Furthermore, CMS reserves the right to withhold payment if an ECCP is not fulfilling activities as outlined in the original FOA, this FOA for phase two, or as defined in the cooperative agreement with CMS.

II. AWARD INFORMATION

Federal funds awarded under this initiative are subject to the new Uniform Guidance at 2 CFR Part 200 and HHS implementing regulations at 45 CFR Part 75, effective on December 26, 2014. This new guidance on Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards will be in effect for the entire duration of the Nursing Facility Initiative project period.

1. Total Funding

Total funding for this phase of the Initiative is approximately \$97 million. Funding for extension of the clinical intervention, including indirect costs, should be based on the amounts being spent under the current Initiative. Applicants should explain any significant deviation between current spending levels and the funding request.

For all other costs, direct and indirect, funding for all other activities described above should be limited to no more than the following amounts over the anticipated project period of performance:

- \$120,000 times the number of expected facilities participating in Group A, plus
- \$60,000 times the number of expected facilities participating in Group B.

CMS reserves the right to alter funding at any time throughout the model period.

2. Award Amount

The Medicare-Medicaid Coordination Office expects to make awards ranging from approximately \$5 million to \$30 million. Amounts awarded to ECCPs may vary significantly depending on the number of beneficiaries in each group and the amount being spent under the current cooperative agreement. Furthermore, after awards have been executed, the use of certain funds will be subject to the approval of CMS as described in this FOA. Therefore, awardees under this FOA may not receive the total award amount (e.g., based on CMS' approval to participate with certain groups).

3. Anticipated Award Date

CMS anticipates awarding phase two of the cooperative agreement on or about January 15, 2016

4. Period of Performance and Budget Period

The anticipated period of performance for this phase of the cooperative agreement is on or about **January 15, 2016** through **October 23, 2020**. Budget periods are intervals of time (usually about 12 months). Budget periods will remain consistent with phase one of the Initiative (each budget period ending on October 23 of each year through 2020).

5. Number of Awards

The Medicare-Medicaid Coordination Office intends to fund up to the seven ECCPs currently operating under this Initiative.

6. Type of Award

Awards will be made through amendments to the existing cooperative agreements.

Termination of Award

Continued funding is dependent on satisfactory performance against operational performance measures, ongoing evaluation results, and whether continued funding is in the best interest of the Federal Government. Projects will be funded subject to meeting terms and conditions specified and may be terminated if these are not met [see Section 1115A of the Social Security Act [42 USC 1315 a](b)(3)(B)].

Anticipated Substantial Involvement by Awarding Office

The Medicare-Medicaid Coordination Office and the Innovation Center anticipate substantial involvement in partnering with the ECCPs by providing technical assistance, team or individual-based counseling, sharing best practices (e.g., via webinars, conference calls, etc.) information on industry trends, and other activities to aid in the success of the Initiative.

CMS will also monitor, measure, and evaluate awardees and their partnering LTC facilities and practitioners on:

- Impact on quality of care, outcomes, and health status;
- Impact on costs; and
- Operational performance, including:
 - Meeting proposed milestones;
 - Producing timely and accurate reports with clear progress on quality and cost performance; and
 - Building and/or enhancing required infrastructure.

CMS reserves the right to approve or terminate any ECCP's partnering LTC facility's or practitioner's participation in this Initiative and adjust funding accordingly.

While awardees are expected to cooperate with the awarding office, operations support contractor, and evaluation contractor, it is not necessary to budget for these activities beyond allowance for staff time for interactions and data reporting. For example, the awardee is not expected to provide working space for Federal participants, etc.

Applications should propose plans and budgets without any assumption of operational programmatic support from the awarding office. For example, the awarding office will not make facilities or other resources available beyond the cooperative agreement award amount. Applications that would require such additional support will be considered non-responsive and will be eliminated from consideration. Applications that require data from CMS should specify this need.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligibility is limited to organizations (ECCPs) currently funded under the first phase of the Initiative as this FOA is approved as a single-source award by the Chief Grants Management Officer.

2. Cost Sharing or Matching

There is no cost sharing or matching requirements under this phase of the cooperative agreement.

3. Foreign and International Organizations

Foreign and international organizations are ineligible to apply.

4. Faith-Based Organizations

Faith-based organizations are eligible to apply provided they meet all other eligibility criteria.

IV. APPLICATION AND SUBMISSION INFORMATION

Notice of Intent to Apply

Potential applicants shall submit a non-binding Notice of Intent to Apply by 5:00 pm, September 9, 2015. The notice should include the following information:

- Name of the applicant organization;
- Name(s) Project Director(s);
- Name of organization point of contact including:
 - Phone number;
 - Email address; and
- A statement confirming the organization's intent to apply.

Notices must be sent to the organization's (ECCP's) respective Project Officer via email:

Nicole Hudson: nicole.hudson@cms.hhs.gov

Nicole Perry: nicole.perry@cms.hhs.gov

Application Submission

Applications must be submitted through the GrantSolutions website ([Grant Solutions Website](#)) through your current account. An application kit for Phase 2 will be posted directly within your cooperative agreement record in GrantSolutions. The application kit will contain all of the information and forms necessary for you to complete and submit your application.

The following items will be available in the Nursing Facility Initiative Phase Two application kit:

Information for the Applicant

The following documents will be available for you to download and review:

- Nursing Facility Initiative Phase Two – Funding Opportunity Announcement (includes appendices A, B, and C)
- Attachment A: Draft LTC Facility Submission Grid
- Attachment C: Draft Practitioner Submission Grid
- Appendix D: Readiness Review Tracker Template

Online Forms

The following forms will be available for you to complete online:

- SF-424 Application for Federal Assistance Version 2
- SF-424A Budget Information – Non Construction
- SF-424B Assurances
- SF-LLL Disclosure of Lobbying Activities

Additional Information to be Submitted

The following items must be uploaded as a file attachment within your application submission.

- Cover Letter (Upload)
- Project Narrative (Upload)
- Budget Narrative (Upload)
 - Provide a detailed breakdown of each budget cost category from the SF-424A for the budgeted costs for all five years. Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A (Year 2 through Year 5) broken out separately by budget period, including a breakdown of costs for each activity/cost within the line item.
 - Upload your completed budget template as a file attachment to this section of the application that will cover costs through the end of the project period (**October 23, 2020**).
- Attachment A: Upload your completed Draft LTC Facility Submission Grid as a file attachment to this section of the application.
- Attachment B: Upload signed letters of intent and practitioner attestation documentation as a file attachment to this section of the application.
- Attachment C: Upload your completed Draft Practitioner Submission Grid as a file attachment to this section of the application.
- Attachment D: Upload resumes and/or job descriptions as a file attachment to this section of the application.

- Indirect Cost Rate Agreement (Upload if applicable)

Note: To assist with the processing of your application, please provide a title on all file attachments (i.e., NF-Submission Grid, NF-Letters of Intent, NF-Practitioner Submission Grid, etc.) that you include in your Phase 2 application.

1. Content and Form of Application Submission

A. Form of Application Submission

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

- Use 8.5" x 11" letter-size pages with 1" margins (top, bottom, and sides). Other paper sizes will not be accepted. This is particularly important because it is often not possible to reproduce copies in a size other than 8.5" x 11".
- All pages of the project narrative must be paginated in a single sequence.
- Font size must be no smaller than 12-point with an average character density no greater than 14 characters per inch.
- All narrative portions of the application (project and budget) must be double-spaced.

SECTION ONE: Project Narrative (not to exceed 20 pages in length, double-spaced):

- A. Organizational Structure
- B. Work Plan
 - i. Group A Work Plan
 - ii. Group B Work Plan
- C. Recruitment and Education Plan
 - i. Group A Recruitment and Education Plan
 - ii. Group B Recruitment and Education Plan
- D. Screening Plan
 - i. Group A Screening Plan
 - ii. Group B Screening Plan
- E. Readiness Review Support Plan
- F. Learning Community Plan

SECTION TWO: Budget Narrative (not to exceed 5 pages in length, double-spaced)

SECTION THREE: Attachments (not subject to page limitations)

- Attachment A: Draft LTC Facility Submission Grid
- Attachment B: Signed letters of intent from prospective LTC facilities or signed agreements to participate (signed agreements preferred) and practitioner attestations.
- Attachment C: Draft Practitioner Submission Grid
- Attachment D: Resumes and/or job descriptions and minimum requirements of key staff.

Other materials NOT included in page limits are:

- Cover letter
- Standard forms (see Overview of Cooperative Agreement Application Structure and Content)
- Indirect Cost Rate Agreement (if applicable)

B. Overview of Cooperative Agreement Application Structure and Content

i. Standard Forms

The following standard forms must be completed and enclosed as part of the application:

- A. SF-424: Official Application for Federal Assistance (see note below)
- B. SF-424A: Budget Information Non-Construction (see note below)
- C. SF-424B: Assurances
- D. S-LLL: Disclosure of Lobbying Activities

Note: On SF-424 “Application for Federal Assistance”:

On Item 15 “Descriptive Title of Applicant’s Project,” state the specific cooperative agreement opportunity for which you are applying: Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform.

- a. Check “C” to item 19, as Review by State Executive Order 12372 does not apply to these cooperative agreements.
- b. Item 18 “Estimated Funding,” shall contain the amount of Federal funding requested for the FIRST BUDGET PERIOD (anticipated date of award through October 23, 2016) of the project only.**

Note: On SF-424A “Budget Information Non-Construction” provide the following budget information:

- Column (2): Insert costs for Year 1 (thru 10/23/16)
- Column (3): Insert costs for Year 2 (thru 10/23/17)
- Column (4): Insert costs for Year3 (thru 10/23/18)
- Column (5): Insert costs for Year 4 (thru 10/23/19)
- Column (6): Insert costs for Year 5 (thru 10/23/2020)
- Column (6): Costs totaled for Years 1 thru 5.

ii. Cover Letter (not subject to the page limits)

The letter (which may be single-spaced and should be a PDF) must be uploaded into the application. The letter shall be addressed to:

Linda Gmeiner
 Grants Management Specialist
 Office of Acquisition and Grants Management
 Centers for Medicare and Medicaid Services
 U.S. Department of Health and Human Services

iii. Application Narrative - Project and Budget Narrative

The application shall address how the applicant will implement phase two of the Initiative, and ultimately, meet the objectives of this project. The required sections of the application are listed below. Also provided is a description of the type of information that is required to be addressed within each specific section. Applications will be reviewed based on how the applicant addresses the required elements of each section, and scored using the point values listed in section V. Application Review Information of this FOA. The application shall be organized by the headings and sub-headings outlined below. Note: CMS may prohibit an ECCP from participating with a particular group; however, applications will be fully evaluated and scored (not penalized) based on direction from CMS.

SECTION ONE: Project Narrative (20 page limitation, double-spaced, for subsections A - F)

The Project Narrative should include the following sections and information:

A. Organizational Structure:

Describes the key ECCP staff and their roles in implementing and managing this phase of the Initiative (including existing staff and positions to be created for this phase of the Initiative). This should include descriptions on which ECCP staff will be responsible for the following activities:

- Educating, recruiting, screening, and submitting information on prospective partnering facilities and practitioners to CMS (or one of its contractors);
- Serving as primary contact for LTC facilities and practitioners and staff responsible for resolving logistical, technical, contractual, or other programmatic issues. A brief description of how the ECCP will provide on-going management of partnering providers;
- Facilitating and managing a localized ECCP learning community.

Activities should be assigned to individuals with the appropriate level of subject matter expertise and the same ECCP staff member may perform more than one of the activities. Resumes or job descriptions and required skills should be submitted as Attachment D (not subject to page limitations).

B. Work Plan:

Identifies the key milestones, tasks, interdependencies, and the responsible parties for each, as well as a related timeline. There should be a separate work plan for Group A and Group B (some overlap is expected). Each ECCP will begin activities from the work plan for Group B with 15 calendar days after receiving approval from CMS. Each work plan will identify key milestones, tasks, interdependencies, and the responsible parties for each, as well as a related timeline. Each work plan should contain, at a minimum, target dates for the following:

- Finalizing a list of LTC facilities to target for recruitment for Group A (this list should be large enough to form an adequate pool of prospective LTC facilities from which to screen and propose a final list of Group A LTC facilities to CMS).

- Confirming a primary and secondary contact at each prospective participating LTC facility.
- Educating the targeted list of LTC facilities on all aspects of the Initiative.
- Educating and finalizing the list of respective practitioners at each LTC facility for both groups (can be different target dates for each group).
- Completing the recruitment of prospective LTC facilities for Group A.
- Completing the screening of practitioners to confirm eligibility to participate and for final submission to CMS (for both groups).
- Completing the screening and prioritization of the list of LTC facilities to propose and submit to CMS for Group A.
- For both groups, assessing LTC facilities' current status as compared to the readiness review requirements (can be different target dates for each group). This will be tracked using a Readiness Review Tracker (see Appendix D for sample template).
- For both groups, completing the requirements in order to pass the readiness review.
- Obtaining executed agreements for participation from each partnering LTC facility.

Target dates proposed should align with the deliverables described in this FOA. However, ECCPs may choose to propose earlier dates (e.g., obtain primary and secondary contacts for LTC facilities prior to the submission of an application for this FOA).

- i. Group A Work Plan
- ii. Group B Work Plan

C. Continued Recruitment and Education Plan:

Describes how the ECCP will identify a pool of LTC facilities and practitioners to be considered for participation. This should include the methods to create awareness among providers and the process for educating prospective participants on the details of the Initiative, such as:

- Identifying and informing LTC facilities and practitioners about the initiative;
- Partnering with leaders and key stakeholders (e.g., associations, state agencies, etc.) to help support engagement among LTC facilities and practitioners;
- The types of venues to be used to convene recruitment and educational sessions (e.g., in-person conferences, webinars, etc.) and the frequency of the sessions; and
- The process for collecting and responding to requests or questions from LTC facilities and practitioners or stakeholders.

There should be a separate plan for Group A and Group B (some overlap of plan elements is expected) with adjustments made as appropriate (e.g., a search for potential LTC facilities for Group B is not needed since those providers are already known). CMS will provide an initial list of facilities potentially eligible for Group A for ECCPs to target for recruitment after ECCPs submit a Notice of Intent to Apply. A draft list of prospective facilities and practitioners should be submitted with the application for this FOA and should include more LTC facilities than needed for Group A (See Attachment A - Draft LTC Facility Submission Grid and Attachment C Draft Practitioner Submission Grid). CMS prefers for ECCPs to prioritize the list of LTC facilities in order of most recommended to least and to identify alternative LTC facilities should any of the recommended LTC facilities not be able to participate. A final list of prospective

LTC facilities and practitioners should be completed within 60 days after the phase two award date.

- i. Group A Continued Recruitment and Education Plan
- ii. Group B Continued Recruitment and Education Plan

D. Screening Plan:

Describes how the ECCP will screen interested LTC facilities and practitioners (from its prospective list) to determine their eligibility for this Initiative. In addition to assessing all of the qualifying criteria listed in 4.1, ECCPs should also collect, assess, and provide the following information to CMS at minimum and as available:

- Number of beds, Medicare-Medicaid certified beds, average daily resident census, average daily number of residents eligible for the Initiative
- LTC facility ownership (for profit or not for profit)
- Chain affiliation or independently owned
- Number of attending practitioners that meet the practitioner eligibility requirements
- Confirmation of executed agreement between LTC facility and ECCP for the terms and conditions of the Initiative
- Hospitalization and/or potentially avoidable hospitalization rates
- Payer source or case mix

The applicant should include the above items and any other pertinent beneficiary, LTC facility, or practitioner information (to be submitted on or in conjunction with Attachment A – Draft LTC Facility Submission Grid).

For Group A, the ECCP should also take actions to identify and recommend a group of preferred LTC facilities very similar to its existing group of partnering LTC facilities. Also to identify alternative LTC facilities should any of the recommended LTC facilities not be able to participate. CMS will provide an initial list of facilities potentially eligible for Group A for ECCPs to target for recruitment after ECCPs submit a Notice of Intent to Apply. A draft list of prospective LTC facilities should be submitted with the application and should include more LTC facilities than needed for Group A (See Attachment A - Draft LTC Facility Submission Grid). CMS prefers for ECCPs to identify alternative LTC facilities should any of the recommended LTC facilities not be able to participate. After an ECCP has developed its final list of prospective LTC facilities and practitioners, the ECCP should then screen the LTC facilities and practitioners to create the final list of proposed participating providers to submit to CMS. In addition to recruiting and educating, ECCPs shall also screen practitioners for participation with this phase, and submit the practitioners associated with the proposed LTC facilities to CMS (see Attachment C – Draft Practitioner Submission Grid). These lists should be submitted to CMS within 90 days after the phase two award date. CMS will ultimately select the LTC facilities and practitioners that will participate.

- i. Group A Screening Plan
- ii. Group B Screening Plan

E. Readiness Review Support Plan:

Defines the process by which ECCPs will assess each LTC facility's current status as compared to readiness review approval criteria and identify any deficiencies. Also, how the ECCP will work with LTC facilities to meet any outstanding readiness review criteria. This would include helping LTC facilities to recruit appropriate staff, assisting in identifying training or certification opportunities, identifying consulting clinicians (e.g., to read EKGs), implementing a structured tool to document and communicate a resident's change in conditions (e.g., INTERACT, AMDA tools), or any other readiness review approval criteria. As compared to the other activities, this plan should be similar for both groups of LTC facilities and practitioners (but tracked separately).

Within 60 days of CMS approval of Groups A and B, ECCPs must submit a Readiness Review Tracker (Appendix D) that includes a timeline for each LTC facility must successfully pass the readiness review by September 1, 2016.

F. Learning Community Plan:

Describes how the ECCP will create a learning community with its groups of LTC facilities and practitioners (Group A and B combined and/or separate). For example, ECCPs may choose to have separate events for each group during the first few months of start-up and then combine the groups into one learning community in the future. This plan should explain how the ECCP will foster communication and sharing with the learning community. This should include information on how the ECCP will garner and track participation, the types of events and materials to be used (e.g., conference call, webinar, in-person, newsletters, reports, etc.), the frequency of events and distribution of materials, and the evaluation of the effectiveness of the events.

SECTION TWO: Budget Narrative (5 page limitation, double-spaced)

Applicants shall supplement Budget Form SF-424A with a Budget Narrative. The Budget Narrative shall include a yearly detailed breakdown of costs for the period of performance (as defined above). Specifically, the Budget Narrative should provide a detailed cost breakdown for each line item outlined in the SF-424A (Year 1 through Year 5) broken out separately by year, including a breakdown of costs for each activity/cost within the line item to support the Initiative. For example:

- The staff (existing or planned additions) that will be allocated to the project and the amount of time allocated to the project (e.g., % of FTE).
- Costs for the activities in the recruitment and education plan (e.g., conferences, webinars, etc.).

The proportion of cooperative agreement funding designated for each activity should be clearly outlined and should justify the organization's readiness to receive funding through 2020 including complete explanations and justifications. The budget must separate out funding that is administered directly by the awardee from any funding that will be subcontracted.

The budget narrative should separately identify the amounts relating to the extension of the clinical intervention approved under Phase I and the amounts relating to the new activities described in the FOA and provide a total for each.

For the extension of the clinical intervention, applications should explain any significant deviations from current spending rates.

For the new activities, applications should state the expected number of nursing facilities that the ECCP can accommodate at the requested funding levels.”

The following budget categories should be addressed (as applicable):

- Personnel
 - NOTE: Consistent with section 203 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) none of the funds appropriated in this law shall be used to pay the salary of an individual, through a grant, cooperative agreement, or other extramural mechanism, at a rate in excess of Executive Level II (\$183,300).
- Fringe benefits
- Contractual costs, including a detailed breakdown of each subcontract
- Equipment (including all computers and cell phone regardless of price)
- Supplies
- Travel
- Indirect charges. Indirect costs shall be supported by an approved Indirect Cost Rate Agreement.
- Other costs, including those not otherwise associated with training and education.

The total budget should include both direct and indirect costs (if applicable).

SECTION THREE: Attachments (not subject to page limitations):

Attachment A: Draft LTC Facility Submission Grid: A draft list of the prospective participating LTC facilities for each group and the relevant qualifying information (please complete template provided). This grid should include:

- A sufficient number of prospective LTC facilities (ECCPs should include more than required for this draft).
- All required information (as available) and LTC facilities listed meet all of the eligibility requirements.

ECCPs should prioritize the list of LTC facilities in order of most recommended to least and to identify alternative LTC facilities should any of the recommended LTC facilities not be able to participate.

Attachment B: Signed letters of intent from prospective LTC facilities or signed agreements to participate (signed agreements preferred) and practitioner attestations including all the relevant requirements from section 4.3.

Attachment C: Draft Practitioner Submission Grid: A draft list of the proposed participating practitioners affiliated with each LTC facility. This should only include practitioners who meet the eligibility requirements and all the required qualifying information (please complete template provided).

Attachment D: Resumes and/or job descriptions and minimum requirements of key staff.

2. Submission Dates and Time

You must submit your application electronically via GrantSolutions at ([Grant Solutions Website](#)) no later than 5:00 PM (Eastern Time (Baltimore, MD) on **October 29, 2015**.

3. Intergovernmental Review

An application for this cooperative agreement is not subject to review by States under Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF-424 (Application for Federal Assistance) as Review by State Executive Order 12372, does not apply to this cooperative agreement.

4. Funding Restrictions

Indirect Costs

If requesting indirect costs, an approved Indirect Cost Rate Agreement will be required to support those costs. The provisions of OMB Circulars A-21 and A-122 govern reimbursement of indirect costs under this funding opportunity announcement. OMB Circulars are available online at: [OMB Circulars Website](#).

Direct Services

Cooperative agreement funds may not be used to provide individuals with services that are already funded thru Medicare, Medicaid and/or CHIP. These services do not include expenses budgeted for LTC facility and practitioner and/or consumer task force member participation in conferences, provision of technical assistance, or attendance at technical assistance conferences sponsored by CMS or its national technical assistance providers for the benefit of awardees.

Reimbursement of Pre-Award Costs

No cooperative agreement funds awarded under this funding opportunity announcement may be used to reimburse pre-award costs.

Prohibited Uses of Cooperative Agreement Funds

- To match any other Federal funds.
- To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g., vocational rehabilitation or education services) or under any

civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

- To supplant existing State, local, or private funding of infrastructure or services, such as staff salaries, etc.
- To be used by local entities to satisfy State matching requirements.
- To pay for the use of specific components, devices, equipment, or personnel that are not integrated into the application.
- To pay for construction or alteration and renovation of real property (A&R).
- To pay for information technology (IT) equipment exceeding 10 percent of the total award. Any equipment, which includes IT, over \$5,000, must be approved by CMS.
- To pay States for the use of any of their data made available for this Initiative.
- To conduct activities that are prohibited by the federal anti-kickback statute (42 U.S.C. 1320a-7b(b)), civil monetary penalties law (42 U.S.C. 1320a-7a), or the physician self-referral prohibition (42 U.S.C. 1395nn).

Other Limitations

A current recipient cannot be awarded a new, renewal, or competing continuation cooperative agreement for any of the following reasons:

- The current project is not progressing in a satisfactory manner;
- The current project is not in compliance with program and financial reporting requirements;
- The applicant has an outstanding delinquent Federal debt;
- No award shall be made until the delinquent account is paid in full; or
- A negotiated repayment schedule is established and at least one payment is received.

V. APPLICATION REVIEW INFORMATION

1. Criteria

This section fully describes the evaluation criteria for this phase of the Initiative. In preparing an application, you are strongly encouraged to review the programmatic requirements detailed in I. Funding Opportunity Description. The application must be organized as detailed in IV. Application and Submission Information, and be submitted by an eligible applicant as defined in III. Eligibility Information. Note: CMS may prohibit an ECCP from participating with a particular group (Group A or B as listed in this FOA. See Program Requirements in Section 4.). However, applications will be fully evaluated and scored based on the groups CMS has determined the ECCP is eligible to participate with (applications will not be penalized if CMS has informed an ECCP that they are not eligible to participate with a particular group).

Your application will be scored with a total of 100 points available. Applications will be reviewed and scored using the point values listed below and based on how the applicant addresses the required elements of each section as described in IV.1.B.iii Application Narrative – Project and Budget Narrative.

SECTION ONE: Project Narrative (50 Points)

- A) Organizational Structure
- B) Work Plan
 - i. Group A Work Plan
 - ii. Group B Work Plan
- C) Continued Recruitment and Education Plan
 - i. Group A Continued Recruitment and Education Plan
 - ii. Group B Continued Recruitment and Education Plan
- D) Screening Plan
 - i. Group A Screening Plan
 - ii. Group B Screening Plan
- E) Readiness Review Support Plan
 - i. Group A Readiness Review Support Plan
 - ii. Group B Readiness Review Support Plan
- F) Learning Community Plan

SECTION TWO: Budget Narrative (30 Points)

SECTION THREE: Attachments (20 Points)

- Attachment A: Draft LTC Facility Submission Grid
- Attachment B: Signed letters of intent from prospective LTC facilities or executed agreements to participate (executed agreements preferred).
- Attachment C: Draft Practitioner Submission Grid
- Attachment D: Resumes and/or job descriptions and minimum requirements of key staff.

2. Review and Selection Process

The review process will include the following:

- (1) An independent, objective review of applications will be conducted. The CMS review panel will assess the application based on the review criteria outlined in section V.1 above to determine the

merits of the application and the extent to which it furthers the purposes of the Initiative. The review panel comments and recommendations will be condensed into a summary statement that will assist CMS in making the final award decision. CMS will use the information to judge the likelihood that the project will be successfully implemented and will have tangible, beneficial outcomes.

(2) A program integrity screening of the applicant, its affiliates, or any other relevant individuals or entities to determine if prior investigations, CMS administrative actions, or claims analysis indicate these entities present a high risk for fraud and abuse under the Initiative.

(3) Applications determined to be ineligible, incomplete, and/or non-responsive based on the initial screening may be eliminated from further review. However, the CMS/OAGM/GMO, in his or her sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

3. Anticipated Announcement and Award Dates

The applicant will receive written notification of the award decision with an amendment to the existing Notice of Award (NoA). An award will be made to the successful applicant on or about **January 15, 2015**.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

The successful applicant will receive an official NoA signed by the CMS Grants Management Officer, OAGM, that will set forth the amount of the award and other pertinent information, including the specific terms and conditions of the award required for the fulfillment of the cooperative agreement. The NoA is a legal document issued to notify the awardee that the award has been approved and that funds are now available for draw down from the HHS Payment Management System (PMS). Any communication between CMS and an awardee prior to issuance of the NoA is not an authorization to begin implementation of a project.

2. Administrative and National Requirements

An organization receiving an award under this cooperative agreement program must meet the requirements of:

Title VI of the Civil Rights Act of 1964;
Section 504 of the Rehabilitation Act of 1973;
The Age Discrimination Act of 1975;
Hill-Burton Community nondiscrimination provisions; and
Title II, Subtitle A, of the Americans with Disabilities Act of 1990.

All equipment, staff, other budgeted resources, and expenses must be used exclusively for the project identified in the awardee's original cooperative agreement application or agreed upon subsequently with HHS, and may not be used for any prohibited uses.

3. Terms and Conditions

In accordance with the FY2012 Appropriations Provision, Department of Health and Human Service (HHS) recipients must comply with all terms and conditions outlined in their cooperative agreement award, including grant policy terms and conditions contained in applicable HHS Grants Policy Statement (HHS GPS), and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable; as well as any requirements or limitation in any applicable appropriations acts.

Standard Terms, Special Terms, and Program Specific Terms and Conditions may accompany the Notice of Award. Potential awardees should be aware that special requirements could apply to awards based on the particular circumstances of the effort to be supported and/or deficiencies identified in the application by the CMS review panel. The Standard Terms and Conditions that are outlined in Section II of the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the NoA).

4. Reporting Requirements

Awardees must agree to fully cooperate with any Federal evaluation of the program and provide reports at the intervals listed in the terms and conditions of the award, and a final report at the end of the cooperative agreement period in a form prescribed by CMS (including the SF-425 "Federal Financial Report" form). These reports will be designed to outline how cooperative agreement funds were used and to describe program progress, as well as barriers and measurable outcomes. CMS will provide a format for reporting in the terms and conditions.

In order for CMS to monitor the awardee's efforts toward reaching the goals of the cooperative agreement program, awardees must agree to provide CMS with information it may require to assess the functioning and effectiveness of the program and to ensure that the cooperative agreement monies are expended for the purposes for which they were awarded.

The awardee must submit the following required reports throughout the period of performance: 1) quarterly progress reports, 2) annual report, and 3) final report. CMS will provide the format for these reports in the terms and conditions.

Program Monitoring

CMS will work with a third party entity (i.e., operations support contractor) to assist in monitoring enhanced care & coordination provider activities. While the operations support contractor will provide CMS with assistance in collecting data and monitoring Initiative operations, CMS will review this information and make any decisions about readiness and performance.

CMS plans to collect data elements to be part of ongoing monitoring for all phases of the model, and these monitoring and surveillance elements will feed into the evaluation. All awardees will be required to cooperate in providing the necessary data elements to CMS and its contractors.

Monitoring will include, but will not be limited to the review of quarterly progress reports of required data and reported in a standard format.

Other responsibilities of the operations support contractor include:

- Validating readiness reviews to help determine readiness ;
- Conducting chart reviews of a sample of LTC facility residents to ensure that hospital care is not being inappropriately withheld;
- Establishing, facilitating, and leading learning and diffusion activities; and
- Monitoring compliance with billing policies and procedures.

5. Federal Financial Report

Awardees will continue to submit the SF-425 Federal Financial Report on a semi-annual basis.

6. Transparency Act Reporting Requirements

New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier sub-award of \$25,000 or more in Federal funds and executive total compensation for the recipient’s and sub-recipient’s five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at [Appendix A to 2 CFR Part 170 Website](#)). Competing Continuation awardees may be subject to this requirement and will be notified in the Notice of Award.

7. Audit Requirements

Awardees must comply with the audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at [Office of Management and Budget \(OMB\) Circular A-133 Website](#).

8. Payment Management Requirements

Awardees must submit a semi-annual electronic SF-425 via the Payment Management System and to the CMS Office of Acquisition and Grants Management. The report identifies cash expenditures against the authorized funds for the cooperative agreement. Failure to submit the report may result in the inability to access funds. The SF-425 Certification page should be faxed to the Payment Management System contact at the fax number listed on the SF-425, or it may be submitted to:

Division of Payment Management
HHS/ASAM/PSC/FMS/DPM
PO Box 6021
Rockville, MD 20852
Telephone: (877) 614-5533

6. AGENCY CONTACTS

All programmatic questions about the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents should be directed to the program email address [**NFI@cms.hhs.gov**](mailto:NFI@cms.hhs.gov).

Interested parties may also contact the associated Project Officers:

Nicole Perry
Nicole.Perry@cms.hhs.gov
(410) 786-8786

Nicole Hudson
Nicole.Hudson@cms.hhs.gov
(202) 260-0661

Centers for Medicare & Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard
Baltimore, MD 21244-1850

Business questions regarding cooperative agreement procedures, fiscal matters, or guidance in completing the application form may be sent to:

Linda Gmeiner
Grants Management Specialist
Centers for Medicare & Medicaid Services
OAGM/ Division of Grants Management
7500 Security Boulevard, M/S B3-30-03
Baltimore, MD 21244-1850
410-786-9954
Linda.gmeiner@cms.hhs.gov

VIII. OTHER INFORMATION

- **Executive Order 13410** (August 22, 2006) ~ “Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs”

EO 13410 is applicable to health care providers, health plans, or health insurance issuers. It states that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall utilize, where available, health information technology systems and products that meet recognized interoperability standards. “Interoperability” means the ability to communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks in various settings, and exchange data such that clinical or operational purpose and meaning of the data are preserved and unaltered.

- **Publications** - All published reports (e.g., articles), both formal and informal, should acknowledge cooperative agreement support with the following footnote "This project was supported with funding from the Centers for Medicare & Medicaid Services." The article must also state the following: *“The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The awardee assumes responsibility for the accuracy and completeness of the information contained in this report.”* **Before submitting a manuscript or a publication, the awardee must consult (e.g., submit a draft) with the CMS Project Officer. When a manuscript resulting from this cooperative agreement is accepted for publication, the awardee must promptly notify the CMS Project Officer of its acceptance and the date it is scheduled to be published.**

APPENDIX A:

PROPOSED QUALIFYING CRITERIA FOR NURSING FACILITY ACUTE CARE BENEFIT

(To be finalized prior to award in accordance with the most updated clinical standards)

1) *Pneumonia:*

Qualifying Diagnosis:

- Chest x-ray confirmation of a *new* pulmonary infiltrate

OR TWO or more of the following:

- Fever >100.4 (oral)
- Blood Oxygen saturation level < 90% on room air or on usual O2 settings in patients with chronic oxygen requirements.
- Respiratory rate above 30 breaths/minute

Symptomatic guidance: Productive cough, increased functional decline

Treatment: Antibiotic therapy (oral or parenteral), hydration (oral, sc, or IV), oxygen therapy, and/or bronchodilator treatments. Additional nursing supervision for vital sign monitoring, lab/diagnostic test coordination and reporting, and personal ADL care (e.g., feeding, ambulation, etc.).

Maximum Benefit Period: 7 days

2) *Congestive Heart Failure*

Qualifying Diagnosis:

- Chest x-ray confirmation of a *new* pulmonary congestion

OR TWO or more of the following:

- Blood Oxygen saturation level below 90% on room air or on usual O2 settings in patients with chronic oxygen requirements.
- New pulmonary rales
- New edema

Symptomatic Guidance: Acute onset of dyspnea (shortness of breath), orthopnea (SOB when lying down), paroxysmal nocturnal dyspnea (SOB waking the patient at night), new leg or presacral edema, and/or 1 kg or greater 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.

Maximum Benefit Period 7 days

3) *Skin Infection*

Qualifying Diagnosis:

- New onset of painful, red, indurated, skin infection requiring oral or parenteral antibiotic therapy.
 - If associated with a skin ulcer 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 supplementation, at least daily wound inspection and/or periodic wound debridement, cleansing, dressing changes, and antibiotics (oral or parenteral).

Maximum Benefit Period: 7 days

4) *Fluid or Electrolyte Disorder, or Dehydration*

Qualifying Diagnosis:

Two or more of the following:

- Reduced urine output in 24 hours or reduced oral intake by approximately 25% of average intake for 3 consecutive days
- New onset of Systolic BP \leq 100 mm Hg (Lying, sitting or standing)
- 20% increase in Blood Urea nitrogen (e.g. 20 \rightarrow 24)
- 20% increase in Serum Creatinine (e.g. 1.0 \rightarrow 1.2)
- sodium \geq 150 or $<$ 130
- 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

5) COPD/Asthma

Qualifying Diagnosis:

- Known diagnosis of COPD/Asthma or CXR showing COPD with hyperinflated lungs and no infiltrates

AND 2 or more of the following:

- Symptoms of wheezing, shortness of breath, or increased sputum production
- Blood Oxygen saturation level below 90% 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 > 30 breaths/minute

Treatment: Increased Bronchodilator therapy, usually with a nebulizer, IV or oral steroids, oxygen, and sometimes antibiotics.

Maximum Benefit Period: 7 days

6) Urinary Tract Infection

Qualifying Diagnosis:

- >100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms.

AND 2 or more of the following:

- Fever > 100.4° F (oral)
- New onset of Systolic BP ≤ 100 mm Hg (Lying, sitting or standing)
- Tachycardia >100
- Peripheral WBC count > 12,000.

Symptomatic Guidance: Dysuria, frequency, new incontinence, altered mental status.

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

APPENDIX B

REQUIRED ELEMENTS FOR 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 this 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 for 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 & 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

APPENDIX C

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 SNF to receive payment). CMS will determine final qualifications based on system assessments prior to program start date.

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 $\geq 19x$ 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 SNF 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.

| General Instructions/Reminders | | |
|--|--|---|
| <p>- CMS prefers for ECCPs to prioritize the list of LTC facilities in order of most highly recommended to least</p> <p>- An LTC Facility Submission Grid must be completed for Group A and Group B. The data elements in each grid are the same with the exception of Column U.</p> | | |
| Specific Instructions/Notes related information requested in the grids | | |
| Column | Question/Item | Instructions and Notes |
| B | LTC Facility Legal Business Name | Enter the facility legal business name. |
| C | Doing Business As (if applicable) | Enter the name of the facility if it is different from the legal business name. |
| D | CCN | <p>Enter the Centers for Medicare & Medicaid Services Certification Number (CCN), also known as an OSCAR number, which is typically a 6 digit alphanumeric identifier for institutional providers. In some cases, the CCN may be a 7 digit identifier.</p> <p>CCNs must be 6, or in rare cases 7, characters, alpha-numeric, without dashes, spaces, or other non-alpha-numeric values.</p> <p>This is the same identifier as the "provnum" reported in Nursing Home Compare .</p> <p>NOTE: CCNs should be formatted as text to include the leading zero. If the CCN begins with a leading zero (e.g., "012345") the leading zero must be entered. If you are cutting and pasting identifiers from another Excel workbook that treats the CCN as a numeric value, the leading zero will have been removed. Please double check to make sure that all leading zeros are present by formatting all cells as text.</p> |
| E | Organizational NPI | <p>Enter the Organizational National Provider Identifier (NPI) that is used by the LTC facility when submitting claims to Medicare.</p> <p>The Organizational NPI must be 10 digits and numeric without any dashes, spaces, or other non-numeric values.</p> |
| H | Is the facility Medicare and Medicaid certified and not excluded from participation in the Medicare or Medicaid programs? | Answer yes or no as to whether the facility is certified and not excluded from participation in Medicare and Medicaid. |
| I | Number of Medicare-Certified Beds | Enter the number of Medicare-certified beds in the LTC facility. This should include beds that are dually certified for Medicare and Medicaid but should NOT include beds that are only Medicaid-certified. |
| L | Estimated Average Daily Number of Residents Eligible for the Initiative -- the "Target Population" | <p>To be eligible for this initiative, a beneficiary must meet ALL of the following criteria:</p> <ul style="list-style-type: none"> - Have resided in the LTC facility for 101 days or more - Enrolled in Medicare or Medicare and Medicaid - 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 managed care plan (e.g., Medicare Advantage) <p>NOTE: Through this phase of the Initiative, the MDS qualifier, used in phase 1, will no longer be applied and only those beneficiaries who have resided in the LTC facility for 101 days or more shall be considered long-stay for the purposes of this initiative.</p> |
| M | Percentage of Total Daily Residents who Meet Eligibility Criteria (column K/column J) | <p>In order to be eligible for this initiative, the LTC facility must have an average daily census of greater than 80 with greater than 40% of the total facility census as long-stay Medicare-Medicaid enrollees in traditional FFS Medicare (excludes those enrolled in Medicare Advantage or residing in a bed that is not a Medicare-certified or Medicare/Medicaid-certified LTC facility bed)</p> <p>If the answer to this question is <40%, the facility is not eligible to participate</p> <p>Note: Beneficiaries enrolled in Medicare Advantage should not be included in this calculation.</p> |
| N | Average Daily Number of Residents Whose Primary Payer is Medicare FFS (i.e., Part A Skilled Nursing Facility Benefit) | Note: Beneficiaries enrolled in Medicare Advantage should not be included in this calculation. |
| O | Average Daily Number of Residents Whose Primary Payer is Medicaid (i.e., Medicaid NF benefit) and NOT enrolled in Medicare Advantage | Note: Beneficiaries enrolled in Medicare Advantage should not be included in this calculation. |
| R | Has the facility had a survey deficiencies for immediate jeopardy to resident health within the last 12 months? | Answer yes or no |
| S | Has the facility reported any Medicare or Medicaid exclusions, sanctions, indictments, probations, corrective action plans, or judgements imposed in the last three years relating to fraudulent or abusive billing practices? | Answer yes or no. If yes provide a description separately. |
| T | Does the facility use technology to support clinical care and interoperable health information exchange (i.e., using technology that supports the creation and exchange of electronic care plans, transformation of assessment data into interoperable summaries, and creation and exchange of interoperable transition of care summary documents) | Answer yes or no |
| U | Estimated Rate of Hospitalizations for Target Population | Enter the estimated number of admissions per 1000 beneficiary days. A response to this question is optional but CMS prefers that it be included. |
| V | Number of Attending Practitioners that Meet the Practitioner Eligibility Requirements in the FOA | <p>In order for practitioners to participate, they must:</p> <ul style="list-style-type: none"> - have carried an average daily census of at least seven long-stay FFS Medicare-Medicaid beneficiaries in the prospective participating LTC facility over the most recent six months; - have all licensure and certification in good standing; and - Not have reported any sanctions, investigations, probations, corrective action plans, or judgments imposed in the last 3 years relating to fraudulent or abusive billing practices; <p>A response to this question is optional but CMS prefers that it be included.</p> |
| W | Average Number of Hours/Day with Onsite RN Coverage | Enter the average number of hours/day with onsite RN coverage. "RN coverage" may include the Director of Nursing only if he/she provides clinical care to residents. |
| X | Letter of Intent or Signed Agreement submitted with application | Indicate whether the ECCP is submitting a letter of intent or signed agreement with this facility as part of this application. |
| Y | Is this a Recommended or Alternative LTC Facility? | For Group A, indicate whether the LTC facility is one of the ECCPs "recommended" facilities or if the facility is being submitted as an alternative in the case of a recommended facility not being approved. Note: Please list LTC facilities in order of preference from most highly recommended to least. This column does not need to be completed for Group B. |
| Z | Primary POC at LTC Facility | Enter the name of the primary point of contact (POC) at the LTC facility |
| AA | Primary POC Phone | Enter the phone number of the primary POC listed in Column V |
| AB | Primary POC Email Address | Enter the email address of the primary POC listed in Column V. This information is preferred but not required. |
| AC | For Group A only: Does the facility have at least a three star overall rating on Nursing Home Compare on the date of the Funding Opportunity Announcement (Yes or No) | Answer yes or no |

| | | |
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| General Instructions/Reminders | | |
| <p>- Separate grids must be completed for Group A and Group B</p> <p>- A practitioner may participate with multiple nursing facilities as long as he/she meets the eligibility criteria with each LTC facility</p> <p>- Each row in the grid represents a practitioners relationship with a specific LTC facility. If you would like to submit a practioner for consideration to participate with multiple LTC facilities, the practitioner should be listed multiple times on the grid(s) -- each row with a different LTC facility.</p> | | |
| Column | Item/Question | Description/Instructions |
| B | First Name | Enter the first name of the practitioner. The practitioner should be listed on a separate row for each unique nursing facility with which he/she is being submitted. |
| C | Last Name | Enter the last name of the practioner. The practitioner should be listed on a separate row for each unique nursing facility with which he/she is being submitted. |
| D | Tax Identification Number (TIN) | Enter the TIN used by this practitioner to bill Medicare for services provided at the nursing facility noted in columns F and G. |
| E | Individual NPI | Enter the individual National Provider Identifier of the practitioner. Must be repeated on each row on which this practitioner is listed. |
| F | LTC Facility Name | Enter the legal business name of the LTC facility with which this practitioner is submitted. Only LTC facilities also included on Attachment A - LTC Facility Submission Grid should be submitted in columns F and G of this grid. |
| G | LTC Facility CCN | Enter the CMS Certification Number associated with the facility in Column F. This must match the CCN submitted on Attachment A - Nursing Facility Submission Grid |
| H | Average daily census carried by this practitioner of long-stay FFS Medicare-Medicaid beneficiaries in the LTC facility noted in columns F and G over the most recent six months | Enter the average daily census for this practitioner at this LTC facility. The daily census should be calculated for long-stay FFS Medicare-Medicaid beneficiaries that meet the criteria in Section 4 of the FOA. The calculation should be an average over the most recent 6 months. Practioners must have an average daily census of at least seven to be eligible to participate with a given facility in this initiative. |
| I | Practitioner Credentials (e.g. MD, DO, PA, NP, APRN) | Indicate the credentials currently held by this practitioner |
| J | Does the practitioner have all licensure and certification in good standing? | Answer yes or no |
| K | Has the practitioner reported any Medicare or Medicaid exclusions, sanctions, indictments, probations, corrective action plans, or judgements imposed in the last three years relating to fraudulent or abusive billing practices? | If yes, provide detail separately. |
| L | Is the practitioner Medicare and Medicaid certified and not excluded from participation in the Medicare or Medicaid programs? | Answer yes or no |
| M | Does the practitioner use technology to support clinical care and interoperable health information exchange? (i.e., using technology that supports the creation and exchange of electronic care plans, transformation of assessment data into interoperable assessment summaries, and creation and exchange of interoperable transition of care summary documents) | Answer yes or no |
| N | Letter of Intent | Answer yes or no |
| O | Phone | Enter the phone number for this practitioner. |
| P | Email Address | Enter the email address for this practitioner. This information is preferred but not required |

| Readiness Indicator | Definition |
|--|--|
| Average daily number of residents in target population | <p>To be eligible for this initiative, a beneficiary must meet ALL of the following criteria:</p> <ul style="list-style-type: none"> - Have resided in the LTC facility for 101 days or more - Enrolled in Medicare (Part A and Part B FFS) - Have not opted-out of participating in the Initiative - Reside in a Medicare or Medicare/Medicaid certified nursing LTC facility bed - Are NOT enrolled in a Medicare managed care plan (e.g., Medicare Advantage) <p>NOTE: Through this phase of the Initiative, the MDS qualifier, used in phase 1, will no longer be applied and only those beneficiaries who have resided in the LTC facility for 101 days or more shall be considered long-stay for the purposes of this initiative.</p> |
| Confirm 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 hrs/day preferred. | Indicate the target date for confirming the 24 hour availability of key staff, and the actual date of confirmation. |
| Number of hours/day that RN coverage is onsite in the NF | Document the number of hours per day that RN coverage is onsite in the NF |
| The ability to start and maintain parenteral (e.g., IV) 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 provide some of these services in the LTC facility (e.g., LTC Pharmacy). | Indicate the target date for obtaining the ability to start and maintain parenteral (e.g., IV) medications and fluids 24 hours a day for eligible beneficiaries by a certified staff member on all units, and the actual date of confirmation of this ability. If using an external company, provide the name of the vendor. |
| Ability to deliver respiratory therapy and oxygen 24 hours/day (LTC facility staff or external consultant). | Indicate the target date for obtaining the ability to deliver respiratory therapy and oxygen (24 hrs/day), and the actual date of confirmation of this ability. If using an external company, provide the name of the vendor. |
| Ability to debride wounds (LTC facility staff or external consultant). | Indicate the target date for obtaining the ability to debride wounds (LTC facility or external consultant), and the actual date of confirmation of this ability. If using an external consultant provide the name of the vendor or consultant. |
| The ability to obtain 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). | Indicate the target date for obtaining the ability to obtain EKGs and access to a clinician (e.g., external consultant) to read and interpret EKGs within 2 hours, and the actual date of confirmation of this ability. If using an external consultant provide the name of the consultant and provider ID (e.g., NPI). |
| 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.) on all units and all shifts. See Appendix B for the required elements of a tool. Note: Separate from this, LTC facilities will need to complete the MDS assessment for beneficiaries experiencing a change in condition. | Indicate the target date for 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.) on all units and all shifts . Enter the name of the tool being used and the actual date of full implementation. |
| Signed provider participation agreement | Indicate the target date obtaining a signed provider participation agreement (between ECCP and LTC facility) and the actual date of full execution. |
| Qualifying information for telemedicine system (if applicable) | If proposing to use telemedicine consults to assess or confirm a beneficiary's condition, provide the name of the telemedicine system being utilized and the date the specifications of the system were submitted to the ECCP for evaluation by CMS. |
| Does the facility have information and specifications related to the health IT used to support assessments, care planning, and/or health information exchange at the times of transitions in care in place? | Answer yes or no as to whether the facility has health information technology currently in place to support care transitions |
| Does the facility have policies in place to ensure the adherence to the conditions of participation and adoption of best practices related to prevention of the six targeted conditions? | Indicate the target date for implementation of policies and the actual date of confirmation |
| Has the facility implemented 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? | Indicate the target date for implementation of structured tool and the actual date of confirmation |
| Has the facility created facility-wide policies and procedures that defines the process followed to prevent acute changes in conditions; specifically identify, but not limited to, the six targeted conditions; and describe the facility's process to transfer a beneficiary to the hospital? | Indicate the target date for the facility to have policies and procedures in place for each of the three areas and the actual confirmation date |
| Comments/Notes (e.g., other relevant information about the LTC facility that will help determine eligibility for participation or likelihood for success) | |

| Number of LTC facilities | LTC Facility | Average daily number of residents in target population | Confirm 24 hour availability (phone or in person) by LTC facility key staff (e.g., Medical Director, Administrator, Director of Nursing, etc.) and attending practitioners (e.g., MP, NP, PA). RN onsite 24 hrs/day preferred. | Number of hours/day that RN coverage is onsite in the NF | The ability to start and maintain parenteral (e.g., IV) 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 provide some of these services in the LTC facility (e.g., LTC Pharmacy). | Ability to deliver respiratory therapy and oxygen 24 hours/day (LTC facility staff or external consultant). | Ability to debride wounds (LTC facility staff or external consultant). | The ability to obtain 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.) on all units and all shifts. See Appendix B for the required elements of a tool. Note: Separate from this, LTC facilities will need to complete the MDS assessment for beneficiaries experiencing a change in condition. | Signed LTC facility participation agreement | Qualifying information for telemedicine system (if applicable) | Does the facility have information and specifications related to the health IT used to support assessments, care planning, and/or health information exchange at the times of transitions in care in place? | Does the facility have policies in place to ensure the adherence to the conditions of participation and adoption of best practices related to prevention of the six targeted conditions? | Has the facility implemented 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? | Has the facility created facility-wide policies and procedures that defines the process followed to prevent acute changes in conditions; specifically identify, but not limited to, the six targeted conditions; and describe the facility's process to transfer a beneficiary to the hospital? | Comments/Notes (e.g., other relevant information about the LTC facility that will help determine eligibility for participation or likelihood for success) |
|---|----------------------|--|--|--|--|---|--|--|--|---|--|---|--|---|---|---|
| Facility Number | Name of LTC Facility | # of Residents | Target/Actual | # of Hours of RN Coverage | Target/Actual/In-house or external (name of vendor) | Target/Actual/Name of Consultant/Consultant ID (e.g., NPI) | Target/Actual/In-house or external (name of vendor) | Target/Actual/Name of Consultant/Consultant ID (e.g., NPI) | Target/Actual/Name of Tool | Target/Actual | Name of System/Submission of Specifications | Health information technology used | Target/Actual | Target/Actual | Target/Actual | |
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| Notes: The above items are the minimum Readiness Review requirements per the CMS FDA. ECCPs may add additional items to the Readiness Review if necessary to determine or assist readiness. | | | | | | | | | | | | | | | | |

| Number of LTC Facilities | Participating Nursing Facility | Average daily number of residents in target population | Confirm 24 hour availability (phone or in person) by LTC facility key staff (e.g., | Number of hours/day that RN coverage is onsite in the NF | The ability to start and maintain parenteral (e.g., IV) 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 provide some of these services in the LTC facility (e.g., LTC Pharmacy). | Ability to deliver respiratory therapy and oxygen 24 hours/day (LTC facility staff or external consultant). | | | Ability to debride wounds (LTC facility staff or external consultant). | The ability to obtain 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.) on all units and all shifts. See Appendix B for the required elements of a tool. Note: Separate from this, LTC facilities will need to complete the MDS assessment for beneficiaries | Signed LTC facility participation agreement | Qualifying information for telemedicine system (if applicable) | Does the facility have information and specifications related to the health IT used to support assessments, care planning, and/or health information exchange at the times of transitions in care in | Does the facility have policies in place to ensure the adherence to the conditions of participation and | Has the facility implemented a structured tool for identifying early signs of a potential change in a beneficiary's | Has the facility created facility-wide policies and procedures that defines the process followed to prevent acute changes in conditions; specifically | Comments/Notes (e.g., other relevant information about the LTC facility that will help determine eligibility for participation or likelihood for success) | |
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| | | | | | | Target/Actual | Actual | In-house or external (name of vendor) | | | | | | | | | | | Target/Actual/Name of Consultant/Consultant ID (e.g., NPI) |
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| Notes: The above items are the minimum Readiness Review requirements per the CMS FOA . ECCPs may add additional items to the Readiness Review if necessary to determine or assist readiness. | | | | | | | | | | | | | | | | | | | |