Proposal for PTAC

Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

Submitting Organization

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Physician-Focused Payment Model Technical Advisory Committee
C/O US DHSS Assistant Secretary of Planning and Evaluation Office of Health Policy
200 Independence Avenue SW
Washington, DC 20201
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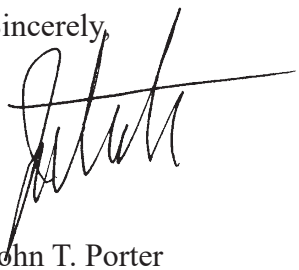
To: The Physician Focused Payment Model Technical Advisory Committee

Avera Health submits the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model for your review. The model addresses the medical needs of a growing population of elderly Americans through timely access to a geriatrician-led multidisciplinary team. Our novel approach of intensive care management has been demonstrated to improve care outcomes, care quality, and reduce total cost of care for beneficiaries in nursing facilities. We would eagerly participate in a model with this structure and incentive and envision it will have broad appeal and adoptions among geriatricians and collaborative organizations across the United States.

Sincerely,



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Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

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i. Abstract

The elderly population living in skilled nursing homes and long term care facilities are frail, medically complex, and manage multiple chronic conditions. Due to the way health care is structured and paid for in the United States, many nursing home residents face challenges in accessing timely, quality care often causing rapid health deterioration and further complications. *Potentially Avoidable Hospitalizations* (PAH) are a symptom of this problem and nursing facility residents experience significantly more of these events than any other patient population. Unnecessary hospitalizations and emergency room visits are harmful, costly and represent a major opportunity to improve health outcomes and quality of life for a vulnerable population.

Avera proposes a new Physician-Focused Alternative Payment Model to align physician, nursing facility, and community care incentives to proactively and holistically care for nursing facility residents. The goal of Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM, hereafter the "Model") is to prevent avoidable escalation of illness for residents, resulting in better quality, better patient experience, and lower costs. This is accomplished through three model drivers:

1) Providing timely, 24/7 access to a geriatrician-led care team through telemedicine
2) Delivering geriatric care management and management of care transitions
3) Mentoring and training long term care staff to improve early identification of resident change in health status

The Model makes available the expertise of geriatricians to a wide panel of residents and clinical teams for proactive, intensive care management using telemedicine. The model is proposed by Avera Health (Sioux Falls, South Dakota). It is based on the successful Avera eLong Term Care (Avera eLTC) program, funded by a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award Round 2 (HCIA2) in 2014.

The Model aligns financial incentives to improve population outcomes, quality of care, and total cost of care. The payment has two parts: a one-time payment for new admission care and a per beneficiary per month payment (PBPM) for post-admission care. The Model payment is comprehensive for all services delivered and is impacted by participants' ability to meet performance criteria on specific quality metrics. The Model lends itself to varying levels of accountability for participants. This proposal recommends two options for consideration by PTAC, each with its own benefits, from which PTAC will choose the payment method best-fit for its definition of alternative. The first option is a *Performance-Based Payment* that is paid throughout the year and will be potentially adjusted in subsequent years, depending on quality performance. The second option is a *Shared Savings Model* that provides the same monthly payments for services delivered but also includes an annual financial reconciliation to determine if savings were generated and assess if any additional shared savings are due to the model participant or, in later years, if any repayment is due to CMS (in the case where savings were not achieved). The *Performance-Based Payment* is a simplified option which encourages broader participation in the program, especially among smaller practices which may not be able to weather the financial risk in a shared savings arrangement and is the preferred option. The *Shared Savings Model* incorporates engagement for Participants by shifting performance risk to the provider in order to potentially achieve more significant cost savings. In both cases, the payment methodology exists to support the Model's care delivery model and works to align incentives to improve patient experience and outcomes.

Section I: Background and Model Overview

Care of frail and vulnerable nursing home residents is complex. The beneficiary is in the charge of a nursing home staffed by nurses and nurse assistants, and typically under the care of a physician unaffiliated with the nursing home. Until recently, there were few financial incentives to keep residents out of the hospital, and limited means to align care strategies between physicians, nursing homes, hospitals, and other providers.

As a result, many Medicare beneficiaries fall through gaps in the system and are sent unnecessarily to the emergency room or hospital, or face long delays in receiving the care they need. Although improving, more potentially avoidable hospitalizations come from residents of skilled nursing facilities and nursing homes than any other patient cohort. Ouslander & Berenson (2011) suggest many hospitalizations are inappropriate, avoidable, or related to conditions potentially treatable outside the hospital setting and cost Centers for Medicare and Medicaid Services (CMS) an estimated $4 billion per year.[1] Medicare pays almost all of the costs of avoidable hospitalizations for dual eligible enrollees (96% in 2009).[2]

There are three interrelated challenges to delivering high quality and effective care to residents:

1) Limited access to timely physician care for high-risk residents
2) Shortage of geriatricians to meet the medical needs of a growing population of elderly Americans
3) Skills gaps in the capabilities of nursing home staff to address the increasing acuity of residents

The Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM, hereafter the "Model") addresses each of these challenges, which are discussed below.

CHALLENGES

1) Limited access to timely physician care for high-risk residents

   Nursing home physician care is typically provided by community providers who spend less than two hours a week caring for residents.[3] Insufficient reimbursement, high call volume, and excessive paperwork create disincentives for caring for this high needs population. In fact, up to 50% of physicians reported that they intended to decrease their involvement in long term care (LTC) because of these burdens.[3] The Levy, et al (2006) Health and Human Services (HHS) report recognizes physicians who only care for a few residents have many other competing demands and may be unavailable for calls during office hours, seeing nursing home patients "as a last priority in evenings and on weekends." This lack of physician availability is demonstrated in the increasing number of resident reports of dissatisfaction connected to the failure to provide physician services for a change in condition.[3] These physician arrangements can create unfamiliarity and communication challenges between the nursing home and Primary Care Provider (PCP), making it difficult to get help during acute episodes.

2) Shortage of geriatricians to meet the medical needs of a growing population of elderly Americans

   Physicians dedicated to nursing home care have been shown to be more available to residents, respond to calls for assistance more quickly, and have lower hospitalization rates than non-specialists.[3] In particular, geriatrician involvement in the care of seniors results in 133 fewer ER visits per 1,000 residents and is believed to reduce cost of care by 10% a year.[4,5] Geriatricians are trained specifically to care for older adults, which includes an emphasis on the unique syndromes and physiological changes of aging, team-based care, a holistic approach to managing health, and a focus on shared decision-making.[6]

   Despite their potential to positively influence care, there is a growing shortage of geriatricians in the U.S.[7] There are 7,293 geriatricians in the United States and more than 22 million individuals age 75 and older, resulting in approximately 3.4 geriatricians per 10,000.[8] Current growth trends indicate by 2040, the number of people age 75 and older will double, but the number of geriatricians will remain the same.[7]

3) Skills gaps in the capabilities of nursing home staff to address the increasing acuity of residents

   Nursing facilities often face challenges with low operating margins, high staff turnover, and difficulties staffing around the clock with qualified nurses. Many facilities do not have a registered nurse (RN) on staff 24/7and rely on Licensed Practical Nurses (LPN), which is linked to a higher likelihood of avoidable hospitalizations.[9] Several studies have found that increasing RN staffing resulted in better clinical outcomes, including decreased hospitalizations.[10,11] Moreover, in the last decade, the acuity of patients treated in nursing homes has increased, posing a new challenge for adequate staffing and training.

Enhanced access to timely care, availability of geriatrician and gerontology services, and appropriate skill training and mentoring of nursing facility staff has shown to improve care delivery and outcomes. And these challenges prove solvable when addressed through the right care delivery model.

MODEL OVERVIEW

The goal of the Model is to prevent avoidable escalation of illness and prevent deterioration of health for residents, resulting in better quality, better patient experience, and lower costs. This is accomplished through three Model drivers:

1) Providing timely, 24/7 access to a geriatrician-led care team through telemedicine
2) Delivering geriatric care management and management of care transitions
3) Mentoring and training long term care staff to improve early identification of resident change in health status

In addition to the drivers of the care model, the payment methodology of the Model supports physician accountability through smart incentives which encourage high performance based on outcome and quality criteria. The care delivery and payment model are discussed below.

Avera has been able to demonstrate success in the care delivery model through the Avera eLTC Health Care Innovation Award Round 2 [Grant Number 1C1CMS331325-01-00] (hereafter, HCIA), resulting in a decrease in unplanned transfers out of the nursing facility and a reduction in the cost of care of $342 per beneficiary per month (PBPM).[12]

Care Delivery Model - How the model would work from the perspective of the eligible professionals who would participate in the model

The Model is built on evidence-based care management practices delivered by a geriatric multidisciplinary team ("Geriatric Care Team"). The care delivery model is implemented across an entire nursing facility, rather than a select group of residents at a facility. This supports the advocacy and partnership of the bedside nursing home staff and allows for true culture change and clinical practice transformation to occur. Participants would be expected to carry out the following Intensive Care Management activities across their nursing home beneficiary population:

- Geriatric Care Management
  - Geriatrician-led, multidisciplinary team (e.g., RN, social worker, pharmacist) monitoring of a resident's care during their nursing home stay, in close collaboration with the attending PCP
  - Risk stratification of the patient population
  - Development of care plans for high risk residents
  - Medication management in coordination with the PCP
  - Evidence-based disease management
  - Behavioral health support, including addressing medications, behaviors, and crises
  - Advance Care Planning
  - Transitional Care Support from the hospital into the nursing facility within 48 hours
  - Medication reconciliation by the multidisciplinary care team
  - Transitional Care Follow-up with patients after SNF/NF discharge within 72 hours
- Timely Access to Care
  - 24 hours a day, 7 days a week telemedicine access to a physician or Advance Practice Providers (APP) on the geriatrician-led team who has real-time access to resident's medical records
  - Real-time provider response to a resident's change in health status

How the model would work from the perspective of the patient's primary care provider and other providers affected by the model

An important part of the Model is partnering effectively with nursing facility staff and attending PCP's. The advocacy and ongoing engagement of these stakeholders has proven critical to success in similar projects.[13] In addition to the Intensive Care Management services Participants

would be expected to meet "Model Participation Criteria" which would include articulating strategies for:

- PCP Care Coordination and Assessment of Satisfaction
- Nursing home engagement and measurement of staff satisfaction
- Assessment of beneficiary satisfaction
- Use of appropriate health information technology to coordinate care between the Geriatric Care Team and the nursing home care team, including telemedicine access
- Nursing home staff coaching and mentorship
- Provision of didactic Continuing Education Credits targeted at identified knowledge and skills gaps
- Use of data to drive continuous quality improvement

The Geriatric Care Team supplements existing services at the facility and across the continuum of care for the resident. The Model offers a continuous population management approach to the nursing facility staff as they interact with dozens of unique PCPs and their unique care management styles. The geriatrician does not replace the PCP, rather supports them through providing access to a Geriatric Care Team which is able to respond immediately to episodic, emergent issues, and off-hour events.

Likewise, the Model does not replace facility staff. Instead, the Geriatric Care Team will partner with the onsite staff and direct culture change and practice transformation towards proactive care and early interventions. This is best achieved through real-time, one-on-one mentoring during direct patient care encounters as well as Continuing Education Credits and other clinical training.

How the model would work from the patient's perspective

Patients will experience the care model as a wraparound service to their nursing facility and primary care. They will continue to see their attending, primary care provider and be cared for by their trusted nursing facility staff, but will also have around the clock access to a Geriatric Care Team who have access to their medical records and relationships with their care team. They will have the ability to opt out of care from the Geriatric Care Team at any point. The patient should experience care that is timely, patient-centered, and focused on the unique needs of the nursing facility population.

Finally, the Geriatric Care Team should consist of multiple clinical disciplines in order to more effectively manage the whole health of the patient. This includes coordination with behavioral health specialists, social workers, and pharmacists and may extend to other specialty care areas, as needed.

What this demonstrates is the vital need for aligning practice and payment. Nursing facilities need an intensive care management team able to safely address the complex and emergent needs of its residents *in situ*. The dominant fee-for-service model is ill-equipped to adequately attend to the inherent complexity, frailty, and vulnerability of this population—and has been shown to be a disincentive to physicians for care delivery.[3] The Model will align the right care delivery with the right financial incentives in order to sustainably deliver appropriate care to the growing population of aging and elderly Americans and prove to reduce spending over time.

Payment Model

The Model aligns financial incentives to improve population outcomes, quality of care, and total cost of care. The payment has two parts: a one-time payment for new admission care and a per beneficiary per month payment (PBPM) for post-admission care. The Model payment is comprehensive for all services delivered and is impacted by Participants' ability to meet performance criteria on specific quality metrics. The Model lends itself to varying levels of accountability for Participants.

This proposal recommends two options for consideration by PTAC, each with its own benefits, from which PTAC will choose the payment method best-fit for its definition of alternative. The first option is a *Performance-Based Payment* that is paid throughout the year and will be potentially adjusted in subsequent years, depending on quality performance. The second option is a *Shared Savings Model* that provides the same monthly payments for services delivered but also includes an annual financial reconciliation to determine if savings were generated and assess if any additional shared savings are due to the Participant or, in later years, if any repayment is due to CMS (in the case where savings were not achieved).

The *Performance-Based Payment* is a simplified option which encourages broader participation in the program, especially among smaller practices which may not be able to weather the financial risk in a shared savings arrangement and, thus, is the preferred option. The *Shared Savings Model* incorporates engagement for Participants by shifting performance risk to the provider in order to potentially achieve more significant cost savings.

Both the payment options rely on elements from existing methods and CMMI demonstration projects—such as Value-Based Purchasing, Advance Pay/AIM, CPC+, and BCPI—in order to leverage and align familiar payment models with a new patient group: the long term care and nursing facility beneficiary population.

Section II: Scope of the PFPM

The Model is designed for geriatricians serving beneficiaries who reside at nursing facilities. "Nursing Facilities" include Long Term Care (LTC), Skilled Nursing Facilities (SNF), and Nursing Facilities (NF). "Beneficiaries" include Traditional Medicare beneficiaries under a Part A qualifying post-acute or short stay, as well as individuals considered long stay or under custodial care. And as used previously, beneficiaries who reside at nursing facilities are referred to as "residents."

Beneficiary Population

There are over 1.4 million nursing facility residents in the U.S. at any given time, both short/post-acute stay and long stay.[14] About four-fifths are considered long stay.[15] In 2014, Medicare alone paid $27 billion for almost 2.5 million post-acute or short stays, with an average length of stay of 26.8 days.[16] This does not include the millions of Medicare beneficiaries living in nursing homes after their Medicare-covered skilled stay. In Avera's experience, 90% of residents are Traditional Medicare beneficiaries. Both short-stay and long stay residents are at high risk of potentially avoidable hospitalizations that impact Medicare spending.

Many of the long stay beneficiaries are Medicare-Medicaid dually eligible, with over 1.08 million recorded in 2005.[17] The dual eligible population utilizes a high proportion of Medicare and Medicaid services and "improving the coordination of medical and long term care" has been identified by CMS as a critical strategy to control costs for CMS. Avera currently serves about 5,000 residents on any given day. A full scale ICM SNF APM program could potentially cover many of the estimated 2.5 million Medicare short stays annually and the estimated 1.0 million Dual-Eligible long stay residents (2005) residing in nursing homes. Adding in an unknown number of self-pay Traditional Medicare long stay beneficiary and the total potential population could be 3.5 million residents in any given year. If PTAC were to recommend the Model be implemented as a demonstration initiative, the beneficiary population served by the program would be dependent on the limited scale tested.

Medicare beneficiaries in nursing facilities may be missed by other alternative payment models which are most likely designed for individuals in primary care and/or for specific conditions. Thus, it is possible that only a small portion of residents are covered by limited bundles or Accountable Care Organization (ACO) arrangements. The Model would broaden participation opportunities allowing almost all residents in participating facilities to be attributed to some form of APM that provides payment incentives to bring about true practice transformation and shared accountability.

The intent of the model is to directly benefit patients with greater physician engagement in their daily care and more timely access to providers when needed. Avera outlines anticipated unintended consequences and outlines strategies to address these potential circumstances in SECTION X: PATIENT SAFETY.

Eligible Providers

The Model will be available for the 7,293 board-certified and board-eligible geriatricians and their teams delivering care to beneficiaries residing in 15,600 U.S. nursing facilities. The payment is billed by the NPI of a geriatric specialty physician and requires him/her to work with a multidisciplinary care team (i.e., the Geriatric Care Team). The Model is most effectively implemented by geriatricians for an entire resident population in order to collaborate effectively with the bedside team in providing urgent care, proactive transition management, and identifying residents' change in health status.

Employed, Independent, and Small Physician Practices

The Model's care delivery model was developed as part of Avera's HCIA2 cooperative agreement. The model was tested on a moderate scale, covering 65 facilities and about 11,000 residents, and was initially delivered by only one geriatrician, demonstrating the feasibility for small practices. The payment model, outlined in SECTION IV: PAYMENT METHODOLOGY**,** provides two options for payment methodologies which might be advantageous to different sizes of practices. The first option includes less risk in the form of reduced payments in future years, which could better enable small physician practices to participate in the model, as it provides an opportunity to slowly transition their practice to APMs. The second option has more accountability since the monthly payments are considered "prepayments on savings," but it allows more mature physician practices the opportunity to share in potential savings created by the Model. The Model is flexible enough to work for both employed and independent physicians.

Ideally, employed physician compensation strategies would align with the goals of the program, including quality performance incentives and appropriate recognition of changes in productivity under team care arrangements.

Interest from other Payers

Medicare is the primary payer for 90% of beneficiaries in facilities, leaving 10% to have other payers such as Medicaid, Medicare replacement, or other sources. As the primary payer for this population, it is necessary for Medicare to be the first adopter of the Model. Other payers have expressed interest but have focused their alternative payment model strategies on areas with greater member volumes. Pending launch January 1, 2018, Great Plains Medicare Advantage, a Medicare Advantage Institutional Special Needs Plan for long term care residents, came forward and agreed to implement the care model in a percentage of its population.

Avera's regional State Medicaid offices have offered support for the program, but have little to gain financially from reducing avoidable hospitalizations of dually eligible beneficiaries, as detailed in the CMMI Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.[18] When Medicaid-covered residents transfer to hospitals the payer shifts from Medicaid to Medicare for the hospital stay. Furthermore, hospitalization may likely benefit State Medicaid if it were to result in a Medicare-qualifying skilled nursing facility stay once the resident returns to the facility.

Anticipated Impacts on Medicare Spending

The Model is clinically based on Avera's HCIA2 program which achieved a savings of $342 PBPM to Medicare based on internal evaluations of two years of data. Avera's results and estimates are in line with the results of the CMMI Initiative to Reduce Hospitalizations among Nursing Facility Residents.[13] Based on this experience, the ICM SNF APM will yield savings to Medicare. Using conservative estimates in which Participants achieve just 50% of Avera's $342 in savings across only half of eligible beneficiaries, Medicare would realize $1.3 billion in savings annually (see Table 1).

Table 1: Estimated Savings to Medicare

Estimated Savings to Medicare	
Number of US Licensed Residents as of 12/31/14	1,400,000
Assume 90% of Residents are Medicare Eligible	1,260,000
Assume 50% of Eligible Beneficiaries are assigned to the Model	630,000
Monthly Cost Savings Based on Achieving $342 PBPM	$ 215,460,000
Monthly Cost Savings Based on Achieving 50% of $342 PBPM	$ 107,730,000
Annual Cost Savings Based on Achieving $342 PBPM	$ 2,585,520,000
Annual Cost Savings Based on Achieving 50% of $342 PBPM	$ 1,292,760,000

Section III: Quality and Cost

The Model will improve health care quality and decrease beneficiary cost of care. These results will be achieved through proactive care management, earlier intervention, and increased support for the facility care team, leading to decreased emergency room visits and decreased transfers to the hospital that result in admission and readmission.

Quality and Cost Evidence for Selected Care Model

Over the last decade there have been several successful initiatives to improve care quality and reduce cost of care among residents. These include:

CMS Evercare Demonstration

> This CMS demonstration used facility-based nurse practitioners in collaboration with primary care physicians to increase clinical care and provide intensive, proactive care management of nursing home residents. Evercare was reported to have reduced hospital admissions by 47% and emergency department use by 49%.[19]

INTERACT II

> Interventions to Reduce Acute Care Transfers (INTERACT) II is a free set of tools and education for nursing facilities focused around early identification, assessment, communication, and documentation of changes in resident status. This quality improvement intervention was evaluated and found to result in a 17% reduction in hospital admissions with projected savings to Medicare of $125,000 per year per 100-bed nursing facility.[1]

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents[1]

> This CMMI demonstration was launched in 2012 with seven organizations representing 143 facilities and 16,000 monthly beneficiaries. Each organization implemented their own care model, which incorporated the required elements of hiring on-site facility staff to focus on improvements related to avoidable hospitalizations, such as medication management and improving communication and coordination. The program evaluation suggested a reduction in hospitalizations and related Medicare costs. The best results (8-9% reduction in all-cause hospitalizations) came from models that used nurses or nurse practitioners for ongoing clinical care rather than education only.

Avera eLTC CMMI Health Care Innovation Award Round 2

> Building on this evidence, Avera received funding from the Health Resources and Services Administration (HRSA) to launch a telemedicine pilot in several LTC facilities in 2012. The results of this program were published in the *Journal of the American Medical Directors Association* in 2016 and available in **Appendix A**. In 2013, Avera

[1] Avera and other South Dakota-based entities were not eligible to apply to the demo because the required average number of beds per facility exceeded the size of entire South Dakota nursing home cohort.

used this experience to apply for the Round 2 Health Care Innovation Award. The model in the application built on the lessons learned from the pilot:

1) The greatest impact on resident outcomes comes from proactive care management rather than support after escalation of illness (urgent care only)
2) Geriatric specialty practice is best suited to dealing with the health of seniors
3) Nursing facility engagement and culture change requires much more than telemedicine access

Today Avera eLTC virtually connects enrolled facilities with a geriatrician-led care team which includes certified nurse practitioners, geriatric-trained pharmacists, licensed social workers, psychiatric nurse practitioners, and registered nurses with gerontology certifications. Avera eLTC's services extend beyond beneficiary care and focus on facility-wide culture change, following the Care Delivery Model.

Now in its third and final year, the HCIA2 project has implemented the Avera eLTC model in 45 facilities in four states, covering a total of 3,600 licensed beds and serving approximately 11,000 beneficiaries. The facilities represented are both rural and urban, nonprofit and for-profit, chain/system affiliated and independent and range from 38 to 187 beds. In addition to the CMMI award locations, Avera eLTC has also expanded to 20 additional locations covering 1,100 licensed beds. Preliminary, internal review of the current Avera eLTC program has shown a reduction in cost to Medicare of approximately $342 per beneficiary per month during the award period. The methodology for this calculation is provided in **Appendix B**. Moreover, the Avera eLTC program has found that 88% of beneficiaries were able to stay in the facility immediately following a telemedicine video encounter with the care team.[12] Staff members report a 98.4% satisfaction rate with the program and beneficiaries in the facility report a 99.6% satisfaction rate.[12] Over two- thirds of the facilities outperform the national average on CMS Nursing Home Compare on metrics for the percent of short stay residents who have had an emergency department visit or who were re-hospitalized.

Performance Measurement

We propose a robust set of quality measures to evaluate the value to beneficiaries, payers, and clinicians. Measures include clinical quality, health outcomes, and indicators of health care cost management as evaluated by federal reporting programs. Programs are asked to independently measure patient experience as part of the Model Participation Criteria. The outcome and quality measures included in the model are currently used as part of the *CMS Nursing Home Compare and Skilled Nursing Facility Value-Based Purchasing* results. This reinforces nursing facility adoption and continued acceptance into existing work flow. There are separate measures included for both short stay and long stay residents.

Participants' performance will be evaluated on their ability to achieve above-average performance or demonstrate measureable improvement towards that goal for key metrics directly impacted by the care model. By including an option for improvement, the model provides incentives for geriatricians to work with lower-performing nursing facilities, thus expands the potential scale for the Model. Additionally, participants will be asked to monitor all other

Nursing Home Compare measures to ensure there is no negative effect from the new care model. A full list of the measures and performance criteria are detailed below and in **Appendix C.**

The following eleven (11) outcome and quality metrics (Table 2) are Scored Quality Metrics. Participants' ability to meet the applicable performance criteria below will affect their payments or savings/repayments under the two payment methodology options (described in SECTION IV: PAYMENT METHODOLOGY and **Appendices D & E**).

Table 2: Scored Quality Metrics

	Short Stay: Health Outcome / Health Cost Management Scored Metrics	
	Measure Description	**Performance Criteria**
1	% of short-stay residents who have had an outpatient emergency department visit	Top 2 quintiles or improve by 5% annually
2	SNF 30-day All Cause Readmission Measure	

	Short Stay: Scored Quality Metrics	
	Measure Description	**Performance Criteria**
3	% of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine	Above the 50th percentile or improve toward the average by 5 percentile annually
4	% of short-stay residents assessed and given, appropriately, the pneumococcal vaccine	
5	% of short-stay residents who are newly administered antipsychotic medication	

	Long Stay: Scored Quality Metrics	
	Measure Description	**Performance Criteria**
6	% of long stay residents with a urinary tract infection	Above the 50th percentile or improve toward the average by 5 percentile annually
7	% of long stay residents who are administered antipsychotic medications	
8	% of long stay resident who have depressive symptoms	
9	% of long stay residents who received an antianxiety or hypnotic medication	
10	% of long stay residents assessed and given, appropriately, the seasonal influenza vaccine	
11	% of long stay residents assessed and given, appropriately, the pneumococcal vaccine	

In addition to the Scored Quality Metrics above, the following thirteen (13) measures (see Table 3) must be monitored; failure to meet the goal on more than five measures will be grounds for removal from the Model.

Table 3: Monitored Quality Metrics

Monitored Quality Measures		
	Measure Description	**Goal**
1	% of short-stay residents who made improvements in function	Above the 50th percentile or not decrease more than 5 percentiles annually. Grounds for removal from the program.
2	% of short-stay residents who were successfully discharged to the community	
3	% of short-stay residents who self-report moderate to severe pain	
4	% of short-stay residents who have pressure ulcers that are new or worsened	
5	% of long stay residents whose ability to move independently worsened	
6	% of long stay residents whose need for help with daily activities has increased	
7	% of long stay high-risk residents with pressure ulcers	
8	% of long stay residents who have/had a catheter inserted and left in their bladder	
9	% of long stay residents who were physically restrained	
10	% of long stay residents who self-report moderate to severe pain	
11	% of long stay residents experiencing one or more falls with major injury	
12	% of long stay low-risk residents who lose control of their bowels or bladder	
13	% of long stay residents who lose too much weight	

These measures were chosen based on their widespread acceptance and use in federal reporting programs. The measures are tested, stable and responsive to the clinical intervention. Data to monitor these metrics comes from CMS quarterly reports as well as the Electronic Health Records (EHRs) which allow for monitoring of clinical information to guide performance improvement activities. Additional evaluation of reductions in beneficiaries' cost of care is provided in SECTION IV: PAYMENT METHODOLOGY.

Currently, CMS does not measure health outcomes or costs for long stay beneficiaries, nor does it measure resident satisfaction. There are also no National Quality Forum (NQF) endorsed measures for these gaps; therefore the model does not currently include these performance domains. Practices are required to assess beneficiary satisfaction as a part the Model Participation Criteria. However, this Model should consider adopting metrics related to outcomes for long stay beneficiaries and beneficiary satisfaction if/when they are standardized by CMS.

While the Model is a Physician-Focused Payment Model, we have chosen to use facility-based metrics to evaluate performance for two reasons:

1) The care model represents a population health management approach for all residents
2) The model is most successfully implemented across an entire facility to ensure the greatest opportunity to meaningfully change clinical practice by bedside clinicians (i.e., fully adopt evidence-based care measures and fully utilize the Geriatric Care Team resources)

Future Measures

CMS has plans to replace Skilled Nursing Facility All-Cause Readmission Measure with the Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure.[20] This metric will be incorporated into the Model after acceptance in order to stay compliant with national

metrics. Similarly, as other relevant Nursing Home Compare and Value-Based Purchasing metrics are updated, the Model's metrics would be updated as well to match.

Nature and Magnitude of Barriers

There are several identified barriers to the Model's success. These barriers can be overcome through the following strategies:

1) Adoption by PCPs will require that the geriatrician-led team communicates and collaborates effectively.

   The geriatricians will need to demonstrate their value through responsiveness to patient concerns, expertise in geriatric medicine, and ability to communicate effectively with physicians. The Model requires applicants to have a plan for physician engagement. Avera also suggests that a CMMI Learning Collaborative for Participants will help practices adopt best practices in regards to PCP engagement.

2) Adoption by staff is critical to the culture and practice change necessitated by the model.

   This barrier was well noted in the evaluation of the CMMI Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.[13] Participants must articulate strategies for nursing facility engagement and measurement of staff engagement. Other required activities such as 24/7 availability, staff education presented by the Geriatric Care Team, and bedside mentoring also facilitate active nursing staff engagement.

3) Adoption by residents will be hindered by a required copay or informed consent before services are rendered, especially among fixed-income residents.

   Other models that have attempted to improve health outcomes and care but have included a copay, such as the CMS Chronic Care Management code, have experienced slow adoption. CPC+ Population Based Payment does not require a copay for global care management activities and illustrates a potential solution to this barrier. In a similar way, the Model aims to avoid this barrier by including no copay as the model is a preventive care management approach.

Section IV: Payment Methodology

The basic underlying payment methodology for the Model is based on a two-tier regular payment ("Regular Payment"): a one-time payment of $252 for new admission care and an ongoing monthly payment of $55 for post-admission care. The Model's Regular Payment is one encompassing payment for all services received through the model rather than payment per encounter or procedure. The $252 for new admission care recognizes the increased resources required to have the Geriatric Care Team available to support every new resident admission to a nursing facility. The $55 per month charge for post-admission care provides for ongoing care for residents staying more than a month in the facility. As a whole, this population is more stable than new admissions and requires fewer resources to manage. The development of two fee levels instead of a blended, or averaged fee, recognizes the differences in care needs depending on the

length of stay of the beneficiary in the facility, most notably between short/post-acute stays and long-stays. Avera is suggesting the dollar amounts based on our experience, and the time and resources required to care for this population as described by the Care Delivery Model.

These payments will be billed to Medicare through the Geriatric Care Team's lead geriatrician NPI number. Participants will bill on the first of the month for all new admissions to the facility based on the number of eligible beneficiaries that were admitted since the last month's billing. Medicare will also be billed for all post-admission beneficiaries in the facility on the first of the month, based on the facility census for the first day of each month. The Regular Payments will be dependent on Participants' ability to meet performance criteria for specified and accepted quality and financial metrics, as discussed below and in SECTION III: QUALITY AND COST.

On an annual basis, Participants' performance will be evaluated against the specified outcome and quality performance criteria. There are two potential back-end models being proposed for the Model's payment methodology: a *Performance-Based Payment* and a *Shared Savings Model*. As discussed below, the *Performance-Based Payment* is a more simplified option which may encourage broader participation in the program and is, thus, the preferred option. However, we understand that PTAC may be seeking a model which meets requirements for Alternative Payment Models (APMs). Thus, the *Shared Savings Model* incorporates the element of engagement for Participants through shared savings. Both payment models leverage various elements from existing programs' methodologies—such as Value-Based Purchasing, Advance Pay / AIM, and BCPI—in an attempt to apply these alternative payment models to the Model's care delivery model.

Please note that the intention for proposing two options for the Model's payment methodology is to demonstrate alternatives for how CMS could choose to implement varying levels of accountability. Avera does not expect CMS to implement both and it is not intended for Participants to choose which payment model applies to them (i.e., the options below are not equivalent to Participants choosing between Tracks 1, 2, and 3 in MSSP).

Performance-Based Payment

Under the first payment methodology option, the *Performance-Based Payment*, the Model's Regular Payments (see Table 4) will be made monthly for all Medicare FFS beneficiaries in facilities that offer Model services, as described above. On an annual basis, quality performance of Participants will be measured against the performance criteria discussed in SECTION III: QUALITY AND COST. The resulting quality score will dictate whether a Participant's future Regular Payments will be reduced by some amount ("Maximum Potential Payment Reduction"), which varies by performance year (as shown below and in Appendix C).

Table 4: Performance-Based Payment Scoring

Variable	Year 1	Year 2	Year 3	Year 4	Year 5
				optional renewal years	
Maximum Potential Payment Reduction	0% (i.e., full payment)	0% (i.e., full payment)	25%	25%	50%
Quality Payment Reduction	No Effect		**High Quality Performance** Meeting performance criteria on 8 or more (of 11) Scored Quality Metrics will result in a quality payment reduction of 0% (i.e., full payment is earned for following year) **Average Quality Performance** Meeting performance criteria on less than 8 but more than 4 (of 11) Scored Quality Metrics will result in a quality payment reduction of 50% (i.e., half of possible payment reduction is enforced) **Low Quality Performance** Meeting performance criteria on 4 or less (of 11) Scored Quality Metrics will result in a quality payment reduction of 100% (i.e., maximum possible payment reduction is enforced)		

For example, if a Participant only meets performance criteria on 5 metrics of the 11 total Scored Quality Metrics (i.e., "Average Quality Performance") in the first year of the Model, the subsequent year's Regular Payments will be reduce by half of the Maximum Potential Payment Reductions (50% × 25% = 12.5% reduction). Thus, the Regular Payments for Year 2 become: $220.50 for new admission payments and $48.12 for post-admission monthly payments.

Shared Savings Model

In contrast to the aforementioned *Performance-Based Payment*, the second option for payment methodology, the *Shared Savings Model*, would incorporate an element of risk to the Participants through shared savings. Any Medicare beneficiaries in facilities which offer Model services but are not attributed to another shared savings program would be attributed lives under this model ("Model Assigned Beneficiaries"). The calculation of Participants' "Earned Incentive", or the potential for eventual shared losses, would be similar to the concept and methodology employed in the BCPI program, with the trigger event being a beneficiary's admission in a participating nursing facility. The resulting bundle(s)[2] would include expenditures from the entire LTC stay as well as a 30-day post-discharge period (with some exclusions, such as oncology-related expenses). Additional details are as follows:

- Full Regular Payments will be made on a monthly basis for all Medicare FFS beneficiaries in applicable facilities, as described in the *Performance-Based Payment*.
- For some beneficiaries, these Regular Payments would be considered a "prepayment on savings."

[2] The *Shared Savings Model* may require the creation of multiple Bundles and Target Bundle Prices for distinctly different types of admissions (e.g., short-stay versus long stay residents and/or different categories of Resource Utilization Groups)

  - If a beneficiary is attributed to any other shared savings program (e.g., MSSP, BCPI, etc.), then the Regular Payments are considered final under this program.
  - If a beneficiary is not attributed to any other shared savings program, then the Regular Payments are considered "prepayments on shared savings" under this Model. The financial reconciliation process for these beneficiaries is described below.
- For those beneficiaries that are attributed to the Model (i.e., not attributed to any other program), the Earned Incentive will be calculated as the difference between a Target Bundle Price and Actual Experience.
  - "Target Bundle Price" is equal to historical spend for Medicare beneficiaries having these types of LTC admissions (inclusive of the LTC admission as well as all readmissions and any other post-acute activity within 30 days of discharge); this bundled cost of care would be risk-adjusted based on a CMS Hierarchical Condition Category (HCC) prospective risk score, similar to the model used for Medicare Shared Savings Program (MSSP).
  - "Actual Experience" is equal to attributed beneficiaries' actual experience for all Medicare FFS Part A and Part B medical spend throughout the LTC stay plus the 30-day period post-discharge; note that the Regular Payments made throughout the year for those beneficiaries would be included in Actual Experience calculation and, thus, would count against savings (i.e., a prepayment on shared savings).
- If Actual Experience is less than the Target Bundle Price, the Participant will have created savings and will receive up to 50% share as an Earned Incentive, dependent on adjustments for quality performance (see Table 5). Earned Incentives will be subject to a cap ("Maximum Earned Incentive") equal to 10% of the Bundled Cost of Care.

Table 5: Shared Savings Model Scoring for Savings Scenario

				optional renewal years	
Variable	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Model Participant's Share in Savings	50%	50%	50%	50%	50%
Quality Adjustment for Savings	No Effect		**High Quality Performance** Meeting performance criteria on 8 or more (of 11) Scored Quality Metrics will result in a quality adjustment of 100% (i.e., full share of savings) **Average Quality Performance** Meeting performance criteria on less than 8 but more than 4 (of 11) Scored Quality Metrics will result in a quality adjustment of 50% (i.e., half-share of savings) **Low Quality Performance** Meeting performance criteria on 4 or less (of 11) Scored Quality Metrics will result in a quality adjustment of 0% (i.e., no share in savings)		
Maximum Earned Incentive	10% (of Bundled Cost of Care)				

- If Actual Experience is more than the Target Bundle Price, the Participant will have realized losses and will be obligated to repay a portion of the prepayments they received

throughout the performance year (i.e., "Repayments" are owed to CMS), which is inversely dependent on any adjustments for quality performance (as shown in Table 6).

- There will also be a limit on potential Repayments owed equal to the total prepayments made for Model Assigned Beneficiaries throughout the performance year.

Table 6: Shared Savings Model Scoring for Losses Scenario

optional renewal years

Variable	Year 1	Year 2	Year 3	Year 4	Year 5
Model Participant's Share in Losses	0% (upside only)	0% (upside only)	25%	25%	50%
Quality Adjustment for Losses	No Effect		**High Quality Performance** Meeting performance criteria on 8 or more (of 11) Scored Quality Metrics will result in a quality adjustment of 50% (i.e., half-share of losses) **Average Quality Performance** Meeting performance criteria on less than 8 but more than 4 (of 11) Scored Quality Metrics will result in a quality adjustment of 100% (i.e., full share of losses) **Low Quality Performance** Meeting performance criteria on 4 or less (of 11) Score Quality Metrics will result in a quality adjustment of 100% (i.e., full share of losses)		
Limit on Potential Repayments Owed	N/A		Repayment of all Prepayments that were made for Model Assigned Beneficiaries, not including payments made for beneficiaries attributed to other shared savings programs		

NOTE	Both payment model options include 13 additional quality measures which will be monitored annually. Failure to meet the goal on more than five of these measures will result in discontinued participation in the program.

Sustainability of Care Delivery Changes

The care delivery changes required in the Model will change the culture and the way care is delivered in the facility. Aligning incentives support this change and payment will provide sustainable long-term sustainability of results.

Risk Adjustment

The *Performance-Based Payment* option does not require payments to be risk-adjusted, as many of the system and performance improvement efforts of the program apply equally regardless of risk. The *Shared Savings Model* will use CMS's prospective Hierarchical Condition Category (HCC) risk score to adjust the Target Bundle Price to reflect the underlying risk of the Model Assigned Beneficiary population.

Comparison and Consideration of other CMS/CMMI Models

The Model is proposed to fill a gap for the nursing facility population which may be missed by many ACOs or bundled payments. The Model provides options for eligible professionals who cannot participate in existing Alternative Payment Models by borrowing from many of the most successful programs. The model's components currently cannot be tested because the value and gains of the Model are at the level of the entire facility rather than by certain providers, beneficiaries, or procedures. As such, a significant majority of the population in the facility has to be included in the Model for it to be successful. Avera considered many other payment models before proposing this Model. These are described below:

The Medicare Shared Savings Program (MSSP) and Accountable Care Organizations (ACOs)

> These have been successfully implemented nationwide and have shown significant cost savings. These programs are poorly suited to nursing facility-wide practice change, as the beneficiary population is covered by multiple ACOs, if they are covered at all. Additionally, ACOs require a one-year attribution period and the average length of stay for short-stay beneficiaries is 26.8 days. The ICM SNF AMP Model would complement MSSP ACOs. In facilities where ACOs cover some but not all of the residents, this Model would provide intensive case management while in the SNF. Model payments made under either option would be counted in the ACO's total cost of care. Savings under the *Shared Savings Model* would not be double paid because the financial reconciliation only applies to beneficiaries that are not already attributed to another program.

Bundled Payments

> Long stay nursing facility residents do not have an anchor hospital stay or procedure that qualify them as beneficiaries under bundled payments. Since not all beneficiaries in the facility would fit in the same bundled payment (if they fit in one at all), there would be gaps in care and inconsistent service between individual beneficiaries, undermining the Model's effectiveness. The proposed Model uses admission to the nursing facility as a consistent anchor event for each eligible beneficiary.

Chronic Care Management (CCM)

> These codes have many requirements that do not fit with a nursing facility care model or cannot be fulfilled by a virtual Geriatric Care Team. CCM also requires a beneficiary copay, creating a barrier to adoption (as previously discussed). CCM code cannot pay for beneficiaries receiving Medicare Part A services, including short-stay residents.

Codes Not Allowed with Model

Geriatricians participating in the Model would not be allowed to bill the following codes (Table 7) for residents under the Model during the covered period. This would not preclude PCPs or other geriatricians from billing these codes for residents.

Table 7: Codes Not Allowed with the Model

Codes	Short Description
99487, 99489	Chronic Care Management
G0506	Assessment/care planning for patients requiring CCM services
G0507	Care management services for behavioral health conditions
99358-99359	Prolonged non-face-to-face evaluation and management services
99307–99310	Subsequent nursing facility services, limit of 1 telemedicine visit every 30 days

Barriers that make the Proposed Model Necessary

In addition to the limitations of existing models discussed above, there are several other barriers in the current payment system which discourages needed changes in the care of residents:

- Copays
  - Other models such as Chronic Care Management require beneficiaries to choose to participate and pay a copay. A copay will hinder patient access and lead to only partial participation, which in turn will create challenges implementing the facility-wide changes needed for practice transformation. If a beneficiary opts out of the Model service upon admission to the SNF, the Participant will not bill Medicare for that individual.
- Financial Incentives
  - In some states, payment policies incentivize hospitalization over treating beneficiaries in place. Value-Based Purchasing has begun to address this issue, but few disincentives exist for physicians to transfer residents to the Emergency Department or hospital. The proposed Model aligns incentives for all parties.
- Restricted Telemedicine Reimbursement
  - Current CMS regulation for telemedicine reimbursement requires that a beneficiary reside in or receive care in a rural area. Furthermore, subsequent nursing facility care services through telemedicine are limited to once per month. Avera's experience, supported by the literature cited in the background, demonstrates that both rural and urban residents face challenges accessing timely, quality care to prevent avoidable escalation of illness. Avera requests the Model be available for all nursing facility beneficiaries.

Section V: Value over Volume

Non-financial incentives

Through the adoption of the Model, facilities are connected 24/7 with a Geriatric Care Team ready and able to promptly assist in care questions and concerns. By creating a quick and simple way to access the care team, the Model supports preventive treatment *in situ* and provides an outlet for changing the culture and accepted protocol in the facility toward proactive, team-based, around-the-clock care.

The outcome and quality metrics mirror the *Nursing Home Compare and Value Based Purchasing* programs, thereby aligning physician and nursing home incentives. Providing

options of either an improvement or an achievement target for the performance criteria encourages physicians to work with both low- and high-performing facilities. Physicians will receive credit for facilities achieving above average performance, or improving at least five percentiles from their previous year. The performance criteria support the CMS Hospital Readmission Reduction Program, as well as the goals of most ACOs and other Advanced APMs, reinforcing its value within the greater medical community.

Financial Incentives

Avera's HCIA2 demonstrated that when employed physicians were compensated for the care of a population of residents, they were energized by the opportunity to focus on the needs of the entire population. The geriatricians engaged in monitoring quality and outcomes and they structured in-depth performance improvement projects in concert with the nursing facilities. Without the HCIA2 funding, they would not have received compensation or reimbursement to do this work.

Avera also experimented with financial incentives to nursing facilities during the HCIA2. These payments were meant to encourage high engagement in the eLTC project plan and goals, including involving eLTC staff prior to patient transfers. They were also meant to align with incentives in the Value-Based Purchasing program. Avera's experience was that the financial incentives to the nursing home were less effective than other engagement strategies in gaining long-term project advocacy and support. Nevertheless, the physicians participating in the Model should be allowed to share part of the payment or savings with nursing facilities as they see fit.

The Model is a new payment that provides a clear financial incentive for geriatricians to provide holistic population health care for residents of nursing facilities. The Model rewards geriatrician teams that partner effectively with nursing facilities in changing practice towards proactive and intensive care management. The Regular Payment is contingent on meeting the outcome and quality performance criteria listed in this proposal, aligning the geriatrician's financial incentives with the goals of CMS. The model is structured with less risk to the geriatricians during preliminary years of the program to provide time to fully implement and hone their care model. This also encourages more risk-averse practices to get two years of experience with the model before accepting reimbursement risk.

Section VI: Flexibility

Accommodation of Different Practice Types

The Model was designed for geriatric practices of all types serving residents. It is recognized that very small, independent practices may find it more difficult to take on the risk or make the investments required. However, the model, particularly the Performance-Based Payment option, is feasible for single or rural geriatrician practices because telemedicine and a multidisciplinary care team allow physicians to share their expertise over a wide geography and population. Additionally, the practice may increase their participation in the Model slowly, recruiting partner nursing facilities and building infrastructure over time. The current care model was established

with a single health system-employed geriatrician, supported by five nurse practitioners, and grew over time to include several new physicians and practitioners.

The model is also meant to work with nursing facilities of all types. The eLTC model has been implemented in urban, rural, and frontier facilities; non-profit and for-profit entities; and among independent and system-affiliated facilities.

Adaptability to New Technology

The care model does not specify any particular type of technology other than the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient and supportive risk stratification and population health tools. With the payment model, practices will have the flexibility to adopt new technologies and techniques that provide additional quality or cost of care benefits.

Operational and Reporting Requirements

The creation of a multidisciplinary care team may be an operational burden for small or independent practices. They may be required to hire or contract for additional clinicians to build a team that will meet the clinical needs of their resident population. However, an effective multidisciplinary team allows the physician to further leverage their time across additional beneficiaries and should be considered an asset, rather than a cost, to the practice. The reporting requirements have been minimized to the extent possible by using existing, publically reported CMS measures which are updated quarterly.

Infrastructure Requirements

- Electronic Health Record
    - Geriatric practices will likely have an existing EHR. This model requires that the practice also have virtual access to the health records at the nursing facility which are increasingly electronic. Typically the expense of secure, web portal access to the facility EHR is borne by the nursing facility. The Geriatric Care Team will have to invest in time and training to learn how to operate in various EHRs.
- Telemedicine
    - Geriatric practices will be required to implement telemedicine infrastructure in the facilities they serve. The cost range of telemedicine technology starts at web-based subscription services available for as little as $250 per month, to higher end solutions that might cost $30,000 upfront. Clinically, these solutions accomplish the same goals but may have different operational benefits to the practice and nursing facility. There are several federal grant programs for telemedicine infrastructure available to smaller, rural practices.
- Workflow Management / Population Management Platform
    - In addition to an EHR, the Geriatric Care Team will need to proactively manage a large population of nursing home residents, including ways to risk stratify the population, develop team work queues and task management, as well as carry out reporting and performance improvement activities. Some of these functions might be available within the practice's existing EHR, patient registry, or population health

platform. However, Avera found it advantageous to create a workflow management tool tailored to the nursing facility populations. Since these same functions can be accomplished in many different ways, including utilizing existing electronic and paper tools, this should not be a large barrier to organizations implementing their own care models.

Section VII: Ability to be Evaluated

The Model includes several metrics detailed in SECTION III: QUALITY AND COST which quantitatively evaluates the efficacy of the model on processes of care, health outcomes, and cost of care. The measures also allow programs to benchmark themselves against the LTC population as a whole, as well as improvement over time.

The quality and outcome goals can be evaluated for the population of residents at any one facility and rolled up to the practice as a whole. Changes in cost of care are best evaluated across the entire population of beneficiaries under the care of a practice. The CMS Nursing Home Compare measures are updated and available quarterly. Timely access to claims data will assist in calculating and evaluating impact on cost of care. The model will rely on CMS standard data gathering and reporting procedures.

There are not currently any evaluations of the proposed Model. However, there is a formal evaluation of the Avera eLTC project under way. Mathematica Policy Research will finalize and release its evaluation sometime after the completion of the HCIA2 project. Avera has detailed its internal findings in SECTION III: QUALITY AND COST and **Appendix B**.

Based on the evaluation of the CMMI Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents[18], Avera suggests including a qualitative evaluation of facility engagement in the care model to compliment the quantitative measures described above. This might include differences in model implementation and satisfaction of LTC staff and PCPs. Findings from this evaluation may serve to further refine the Model Participation Criteria long term.

Section VIII: Integration and Care Coordination

The purpose of the Model is to eliminate silos which often exist between nursing facilities, PCPs, hospitals, and other health care services. The Geriatric Care Team serves as a linchpin between the parties—following the resident through transitions, identifying and bridging care gaps, and facilitating optimal communication between the nursing facility and PCP. The geriatrician can virtually assess the patient then have a brief and effective provider-to-provider conversation with the PCP to discuss changes to the care plan. This prevents delays in care (e.g., while the PCP tries to work a resident into his or her schedule) and it prevents the tendency to send the resident to the emergency room for further assessment after a hard-to-interpret call from the nursing facility.

Geriatric Care Team

The geriatrician provides overall Geriatric Care Team management including staff training, protocol set up, and performance improvement. On a beneficiary level, the geriatrician leads the development of the individualized care plans for high risk beneficiaries as well as providing direct specialty geriatric care in coordination with the primary care physician. The Geriatric Care Team then supports and coordinates care for beneficiaries. Other suggested members of the care team include gerontology trained or certified advance practice providers, pharmacists, social workers, nurses, and behavioral health practitioners. Pharmacists review medication lists for polypharmacy, appropriateness, and optimal disease management. This pharmacist review has a disease and risk focus and occurs in addition to the contractually required pharmacy review traditionally provided by the nursing facility. The Licensed Social Worker concentrates on discharges and transitions of care, high quality advance care planning, and palliative care support. The RNs assist with data gathering and task completion, such as ensuring the critical plan components (like lab follow-up or serial weights) are occurring. Additionally, they provide nurse-to-nurse support and mentoring for facility staff. Avera eLTC has found this team, along with a Nurse Practitioner of Psychiatry, to be the best composition to support beneficiaries, sites, and the PCPs in care coordination and cost management.

Care Coordination

The care team is expected to operate off of a shared clinical care plan and record. Ideally, they will have direct access to the nursing facility EHR as described in SECTION VI: FLEXIBILITY. The Geriatric Care Team is specifically tasked with care coordination and care transitions. During the entire process, the care team coordinates and collaborates with the beneficiary's PCP through faxes, chart notes, and direct phone calls as needed.

Changes in Workforce

The model does not require additional staff for the nursing facility or PCP. Conversely, it should lend support to these teams and reduce work burdens. Based on Avera's experience, it is expected the model's emphasis on staff support and mentoring will improve nursing facility staff satisfaction and reduce turnover—a key goal in SNFs. The model's use of telemedicine for 24/7 availability reduces the PCP's burden to be on-call or to make a care decision without ability to perform a full examination.

Accountability

The model ensures each key stakeholder has accountability, whether financial or qualitative. Nursing facilities' performance is measured through programs such as Value-Based Purchasing and Nursing Home Compare. The PCP also benefits, both under MACRA, MIPS, and Advanced APMs, from reduced total cost of care, lower Medicare Spending Per Beneficiary (MSPB), lower all-case and condition specific admission/readmission metrics, as well as improved clinical quality metrics in this population.

Section IX: Patient Choice

The Model's interventions, such as intensive care management, transitional care support, and urgent care will be included in the nursing facilities' consent for treatment and apply as long as the beneficiary is in the facility. The importance of the facility-based approach (in which a majority of beneficiaries are covered to create true cultural change in the care patterns) has been described above. Beneficiaries can choose to opt-out of services and receive care at the clinic or emergency room.

In Avera's experience implementing and developing this model, very few beneficiaries have chosen to opt out of the services. The Avera eLTC program has experienced high rates of staff and beneficiary satisfaction, 98.4% and 99.6% respectively, and expects similar results for other organizations.[12]

The virtual population health model allows the care to be accessible regardless of geography, disability, race, ethnicity or gender. The elderly, a disparate population, are directly served by the model. Additionally, the Model addresses mobility and dementia-related accessibility issues through avoided transfers. Based on Avera's experience, the Model is expected to be successful in both urban and rural areas, and will expand the geographic reach of CMS APMs by serving rural and frontier beneficiaries.

Section X: Patient Safety

The Model is focused on providing enrolled beneficiaries with the right care at the right time in the right place. The Model will reduce potential beneficiary harm which could be caused by unnecessary transfers and/or by allowing illnesses to progress to the point where more serious intervention is required. Avera's experience implementing the Model has shown enhanced care and access, rather than disrupted or stinted care.

During transfer decisions, the Geriatric Care Team provides expert opinion and review of the beneficiary situation, ensuring every transfer is appropriate and best for the beneficiary. The beneficiary's PCP, though not financially accountable to the model, is kept informed and ultimately in charge of care. This double-physician review of care decisions provides integrity to the model and significantly reduces potential for stinting care.

Avera tracks beneficiary satisfaction to ensure the beneficiary feels well-cared for, listened to, and receives care in adherence to his or her wishes. As part of the Model Participation Criteria, it is required of organizations implementing the Model to track measures to ensure beneficiary comfort and satisfaction.

Section XI: Health Information Technology

The Model relies on several forms of health information technology, including EHRs, telemedicine, and possibly a workflow management or population health management platform as described in SECTION VI: FLEXIBILITY. Access to the nursing facility's EHR ensures flexibility, privacy, continuity of care, clear communication between various clinical stakeholders, and eliminates the need for interoperability between EHRs. Privacy and security

policies meeting HITECH/HIPAA will govern and protect access to Personal Health Information (PHI).

Telemedicine is a key leverage point of the model, allowing the Geriatric Care Team to serve beneficiaries in many communities and, therefore, enhance patient experience and the efficiency of care delivery. Telemedicine sessions should be conducted via encrypted video and/or secure, private networks to ensure patient privacy, under HITECH/HIPAA. Physicians will have the flexibility to choose from many types of secure, two-way video telemedicine options.

The cost, quality, and performance of Participants should be publicly available by CMS and on participating organization websites.

Section XII: Supplemental Information

Potential Infrastructure Investments for CMS

The Model is not anticipated to cause significant infrastructure investments or changes at CMS.

As discussed previously, the Model utilizes existing CMS quality and performance metrics and does not create additional work for quality tracking and reporting. A different scoring mechanism will be needed for the annual reconciliation process of the Model. Further discussion of this scoring methodology can be found in SECTION III: QUALITY AND COST and in the Appendices. Additional data, including but not limited to claims data, may be needed to assess performance over time and to improve upon risk stratification methodologies.

If accepted, the Model will use existing claim forms and require establishing an ICD-10 code, or similar mechanism to allow billing. In addition, the Model will require an annual end-of-year financial reconciliation process which takes the calculated quality score to determine future years' Regular Payments under the *Performance-Based Payment* option or, the Participants' share in and amount of savings or losses under the *Shared Savings Model*. As part of the reconciliation process, CMS will need to provide reports to Participants with their performance information and potentially may want to provide reports throughout the year, as well (e.g., quarterly beneficiary assignments).

In the *Performance-Based Payment*, there would be a system which allows CMS to correctly reimburse Participants at the potentially reduced Regular Payment levels in subsequent years if quality performance is below certain thresholds.

In the second option, the *Shared Savings Model*, the year-end reconciliation process requires CMS to identify the beneficiaries not attributed to any other shared savings program (e.g., MSSP or BCPI) in order to designate them as Model Assigned Beneficiaries. Then, CMS will need to set Target Bundle Price(s) equal to historical spend for Medicare beneficiaries having these types of LTC admissions, risk-adjusted based on CMS's prospective HCC risk score. Additionally, CMS will need to calculate Actual Experience as the total medical expenditures for Medicare FFS Part A and Part B throughout the LTC stay plus the post-discharge period for all Model

Assigned Beneficiaries. The bundled cost of care reconciliation would be similar to BPCI program and, thus, would not require significant effort to implement.

The Model requires CMS to create an application process to evaluate applicants' capabilities and confirm their capacity to execute on the care delivery model and meet Model Participation Criteria established for program acceptance (see SECTION I: BACKGROUND AND MODEL OVERVIEW for specific criteria). Throughout the life of the program, CMS will monitor Participants' adherence to the care model and related Model Participation Criteria of the program. Additionally, CMS will likely want to monitor the effected beneficiary population for any unintended consequences which this care delivery model may have.

Section XIII. Endnotes

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Appendices

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Original Study

Implementation of Telemedicine Consultation to Assess Unplanned Transfers in Rural Long-Term Care Facilities, 2012–2015: A Pilot Study

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A B S T R A C T

Introduction: Public and private entities in the United States spend billions of dollars each year on potentially avoidable hospitalizations. This is a common occurrence in long-term care (LTC) facilities, especially in rural jurisdictions. This article details the creation of a telemedicine approach to assess residents from rural LTC facilities for potential transfer to hospitals.
Methods: An electronic LTC (eLTC) pilot was conducted in 20 pilot LTC facilities from 2012-2015. Each site underwent technologic assessment and upgrading to ensure that 2-way video communication was possible. A new central "hub" was staffed with advanced practice providers and registered nurses. Long-term care pilot sites were trained and rolled out over 3 years. This article reports development and implementation of the pilot, as well as descriptive statistics associated with provider assessments and averted transfers.
Results: Over 3 years, 736 eLTC consultations occurred in pilot sites. One-quarter of consultations occurred between 10 PM and 9 AM. Overall, approximately 31% of cases were transferred. This decreased from 54% of cases in 2013 to 17% in 2015. Rural pilot facilities had an average of 23 eLTC consults per site per year.
Discussion: Averted transfers represent a dramatic benefit to the residents, as potentially avoidable hospitalizations cause undue stress and allow for nosocomial infections, among other risks. In addition, averting these unnecessary transfers likely saved the taxpayers of the United States over $5 million in admission-related charges to Centers for Medicare and Medicaid Services (511 avoided transfers × $11,000 per average hospitalization from a LTC facility).
Conclusions: Overall, the eLTC pilot showed promise as a proof-of-concept. The pilot's implementation resulted in increasing utilization and promising reductions in unnecessary transfers to emergency departments and hospitalizations.

Potentially avoidable hospitalizations (PAHs) from long-term care (LTC) facilities cost the United States taxpayers an estimated $11,000 per admission, on average.[1,2] If a substantial proportion of these transfers could be averted, hundreds of thousands of patients would avoid the unnecessary stresses, infections, and other adverse effects associated with hospitalizations.[1] Hundreds of millions to billions of dollars could also be saved.[1–3] Reducing PAHs, especially in the form of readmissions, is a major national objective.[4] Because LTC facilities are a major source of hospital admissions and readmissions, they are a natural part of public and private initiatives in this arena.[1,5–7] The Agency for Healthcare Research and Quality estimates that PAHs accounted for 35% of all-cause hospitalizations among skilled nursing facility residents in 2008.[8] One potential avenue for decreasing PAHs is telemedicine.

In the late 1990s and early 2000s, telemedicine broadly was in its infancy, and even more so specifically in the LTC arena.[9–11] Cost, technical issues, and acceptance of the use of telemedicine in this

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context were all identified as significant barriers. However, organizations also began to research the potential benefits for telemedicine, especially around impacting a particularly problematic aspect of care—when and whether to transfer a resident to a hospital.[12–14] This transfer decision was especially problematic in rural areas and during nights and weekends, where it might be more difficult to get an on-call clinician to a long-term facility in a timely fashion to either assess for a transfer or attend to an otherwise nonurgent issue. Research has shown telemedicine brings potentially substantial savings and improvement in a patient's quality of life associated with averting PAHs.[1–3,15–20] Telemedicine may also provide a reasonable compromise to the Centers for Medicare and Medicaid Services' (CMS) proposed rule requiring onsite evaluation prior to transfers of a LTC resident. The provision's onsite evaluation requirement has been challenged by facilities and trade groups as "dangerous for patients", too costly, and burdensome, especially for rural jurisdictions where there may be a lack of appropriate providers in proximity.[21,22] CMS has received over 9800 comments about its proposed package of reforms for LTC providers aimed at improving patient safety and quality of care, and saving money (CMS-3260-P).[23]

LTC in the Avera Health System

Avera Health is an integrated health system spread over a wide region of Iowa, Minnesota, Nebraska, and South Dakota and includes 32 hospitals, primary care clinics, and several postacute facilities. Avera's systems experience many of the same transfer issues identified by scholars and policymakers over the past decade.[22,24] In addition, Avera faces challenges in the provision of LTC to residents who may need to access urgent and/or specialty outpatient healthcare in their community. Residents largely live in small, geographically dispersed rural communities that are facing the broader issue of a growing shortage of physicians and other healthcare workers.[25–27] In addition, residents are often medically complex and/or frail, which can make transfers challenging.[28] This article details the conceptualization and implementation of electronic LTC (eLTC) operations, which serves 34 facilities and 5000 residents as of early 2016. The article details implementation of an initial pilot, funded by the Health Resources and Services Administration's Federal Office of Rural Health Policy (FORHP), which led to a recently initiated eLTC scaling-up project funded by a multimillion award from the federal government.

Development and Implementation

Avera's eLTC pilot model, which launched in 2012, represents the culmination of over a decade's worth of work in the creation of telemedicine infrastructure, programs, and processes. In 2002, Avera partnered with a technology firm to create an electronic intensive care unit (eICU™) care program. This eLTC model was conceived out of necessity; Avera's main base of operations (South Dakota) is largely rural, and many of the patients and ICUs within the region needed instant access to high-quality clinicians during urgent and emergency events. The eICU program grew into Avera's eCARE approach, which includes eEmergency, ePharmacy, eCorrectionalHealth, and now eLTC. Avera's "virtual health system" serves 545,000 square miles across 10 states and has provided services to over 965,000 patients at 250 locations; its eEmergency service line is in 10% of the nation's Critical Access Hospitals.[24] eLTC services are among the newest part of the virtual medicine program at Avera and have presented somewhat different challenges than previous programs in the eCARE suite.

By their nature, LTC facilities exist in, and are reflective of, their communities, both urban and rural. The rural communities, especially, were the focus (and driver) of the eLTC expansion. On average, the 14 sites that were part of the FORHP-funded pilot were in communities with fewer than 10,000 people. The communities largely consist of below- or at-poverty individuals.[29]

Conceptualization of an eLTC Pilot Program

The eLTC project was born out of challenges inherent to these populations in a rural context, such as high acuity LTC patients and fewer providers, especially in specialty care. Internal quality reviews of Avera's system's and affiliated LTC transfers revealed that a sizable proportion of transfers to emergency departments and subsequent hospitalizations were potentially avoidable. Complex, substantial needs had been identified, and Avera leadership believed eLTC might be an avenue to address these needs. The practicality of a pilot grew out of early research highlighted by the American Telemedicine Association, especially Weiner's 2004 study on using a portable telemedicine system to facilitate connection to on-call physicians between 5 PM and 1 AM.[13] The study's findings suggested Avera could potentially improve quality of care while avoiding unnecessary transfers.

In 2010, the eCARE group concluded Avera would implement a 24/7 pilot model of telephonic- and video-based consultation in some of our rural and extremely rural facilities. This pilot would involve installing 2-way video and peripherals, allowing real-time communication between residents and providers in our facilities with on-call specialists. Specialty equipment, such as a 2-way stethoscope and high-definition camera, allowed providers to listen to lungs, heart, and abdomen at a distance, as well as gaining a closer view of the patient as needed.

A core group of staff were hired, including a director of eLTC, a service line manager, 2 advanced practice providers, and 3 registered nurses. Avera staffed the telehealth "hub" that eLTC pilots contacted with advanced practice providers and registered nurses. Next, the program created information technology (IT) requirements for each pilot site; the process is outlined in Table 1. The program staff ascertained that some sites would more easily be able to adopt the desired mobile platform approach than others; for those sites that were not mobile-ready, the IT infrastructure was upgraded. Staff implemented a number of processes to ensure smooth rollout of the pilot program, including quarterly meetings with leadership, the creation of an implementation plan (with

Table 1
Implementation Process for Facility eLTC Readiness

Initial conversation and needs assessment	Identify lead and key contacts at the facility; send materials; meet with staff and complete site assessment; send provider information documentation
Local leadership on-boarding	Obtain facility demographic information, conduct presentations, tour facility, obtain network upgrade quotes
Contracts	Send service agreements, physician letters, connectivity contracts, bill of materials, and meet with staff and providers
Implementation	Enable EHR access, schedule weekly implementation meetings, install and test equipment, train staff, provide informational materials to residents
Training	Deliver site training for leadership and staff including workflow redevelopment, conduct extensive technology checks, schedule planned follow up calls to address post-implementation issues or training needs, schedule monthly eLTC program calls
Implementation finalized	Resolve outstanding issues, create after-action report, establish process for monthly site reports

EHR, electronic health record.

stakeholder review, Table 1), creating educational modules, establishing billing procedures for on-camera video encounters, and leveraging decision support tools.

Once each facility was assessed as a potential eLTC pilot, a number of phone calls occurred between the eCARE team and facility staff. Training and the development of protocols also occurred with the administrator, director of nursing services, maintenance staff, and charge nurses. Given the emphasis on practice transformation, protocols and workflows were considered key "plug and play" elements for other facilities interested in adopting the eLTC approach. Each site then gained access to all eLTC components and services, including access to distance specialty services, such as Infectious Disease, Wound Care, Cardiology, Nephrology, and others; consultation services for ventilator including bi-pap assistance from an eICU intensivist; consultation services from pharmacists for drug administration, side effects, or drug interactions; emergency assistance, if needed through electronic emergency department physicians; and assessments for transfer to hospitals via on-call eLTC providers.

One of the main outcomes of interest in the pilot was the proportion of residents who needed transfer after assessment with an eLTC provider. Each consultation occurred with eLTC in conferring with staff at the resident's facility. The resident was either recommended for transfer to an inpatient facility, to receive treatment at the current facility (no transfer), and, in a few cases, the eLTC provider recommended the resident should remain at the current facility but did not need further treatment for their chief complaint. The pilot participants heavily used the Interventions to Reduce Acute Care Transfers tool.[30] The Interventions to Reduce Acute Care Transfers tool has grown to become a best practice in addressing PAHs.[31,32] Prior to the pilot, patients at these LTC facilities would very likely have been transferred, based on previous patterns of transfers. As such, situations where a transfer did not occur is referred to as an "avoided" or "averted" transfer.

Pilot Results

The pilot began at 5 sites at the beginning of 2012, eventually increasing to 14 sites in 2014, 20 in 2015, and 34 eLTC sites as of mid-2016 (Figure 1). There were 76 consults in 2012, growing to 386 in 2014, and trending above 500 in 2015 (based on 175 consults in January–April 2015). Pilot facilities had an average of 23 eLTC consults per site per year. The majority of eLTC consultations (57%) occurred between 9 AM and 5 PM. Eighteen percent occurred between 5 PM and 10 PM, and 25% occurred between 10 PM and 9 AM.

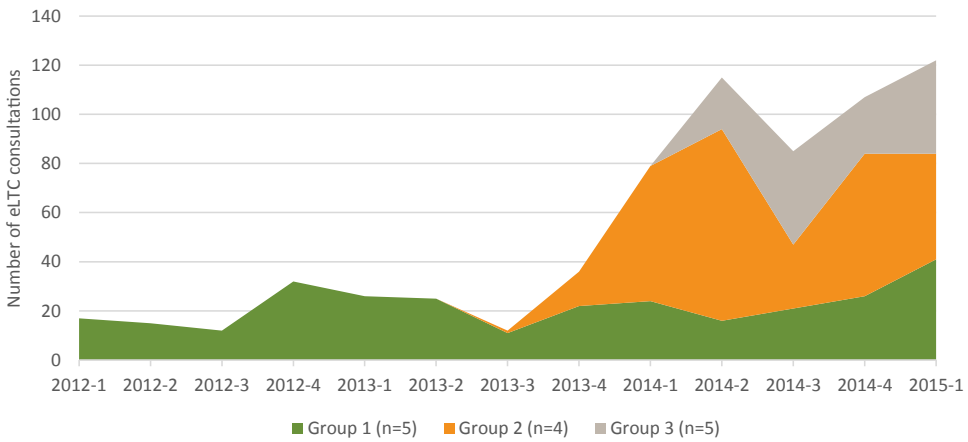
Between January 2012 and April, 2015, the eLTC pilot involved 736 two-way video transfer consultations and 863 other telephonic encounters. The transfer consultations resulted in 511 potential transfers that the provider determined as avoidable (Table 2). The chief complaints included shortness of breath (24%), skin complaint (24%), upper respiratory infection (14%), fever (13%), neurologic/syncope (12%), joint/limb pain (10%), abdominal/gastrointestinal complaint (10%), urologic (9%), weakness/dizziness (8%), and all others (32%). Among these common chief complaints, the highest proportion of transfers were for neurologic/syncope issues (66% of cases were transferred), abdominal/gastrointestinal (45%), and shortness of breath (44%). The lowest were for urologic (5%) and skin complaints (11%). In the course of the pilot through April, 2015, 69% of cases were judged as not needing a transfer by the eLTC providers (Table 2). Before implementation of eLTC, patients with similar complaints would have likely been transferred.

Utilization of eLTC services increased substantially over the course of the FORHP grant period, as did averted transfers as a percentage of total encounters. During 2012, 39% of resident video encounters resulted in a transfer. The transfer rate increased to 54% in 2013 as more sites were added, and decreased to 17% by 2015.

Discussion

Pilot Highlights

Over the course of 3 years, over 500 potential transfers were deemed unnecessary by skilled providers via the eLTC pilot, and these residents remained in their respective facilities. These averted transfers represents a dramatic benefit to the residents, as PAHs cause undue stress and allow for nosocomial infections, among other risks.[1] In addition, averting these unnecessary transfers likely saved the taxpayers of the United States over $5 million in admission-related charges to CMS (511 avoided transfers × $11,000 per average hospitalization from a LTC facility).[1,2] The observed increase in eLTC utilization and averted transfers was a direct result of continuous training, education, and monthly follow-up meetings with partnering facilities.



Note: Quarter 2 of 2015 is excluded as the pilot period ended in April

Fig. 1. Expansion of eLTC program, by quarter and groups of participating sites, 2012–2015. Note: Quarter 2 of 2015 is excluded as the pilot period ended in April.

Table 2
Two-Way Video eLTC Consultations and Transfers, Count, and Percent of Annual Consults, January 23, 2012 Through April 30, 2015

Year	Total Number of eLTC Consults	No Transfer	Transferred
2012*	76	46 (61%)	30 (39%)
2013	99	46 (46%)	53 (54%)
2014	386	273 (71%)	113 (29%)
2015†	175	146 (83%)	29 (17%)
Total number of eLTC consults	736	511 (69%)	225 (31%)

Annualized trends from the first one-third of 2015 would equal approximately 530 total consults.
*Excludes 22 days in January.
†Partial year, excludes 67% of the year (246 days).

Overcoming Technical Challenges

Several challenges and barriers were identified and overcome during the FORHP-funded eLTC pilot. The first challenges revolved around IT capacity and technical issues, especially getting sufficient network bandwidth into the facilities for adequate high quality video. A second technical challenge was the video location. In prior telemedicine service lines such as eEmergency, Avera had relied upon devices that were in a fixed location and used a similar approach when eLTC was first implemented. However, because of space constraints at facilities, telemedicine equipment was often located in small, inconvenient locations that created significant barriers to use. The pilot then switched all equipment to mobile carts, which helped increase utilization substantially.

Overcoming Cultural Challenges

Another barrier included cultural transformation, both for LTC staff and clinicians. Over the years, LTC staff had become very used to quickly transferring any patients with substantial health concerns. The approach to safely treating a larger percentage of patients in place was a very new approach for most of the LTC staff and required a lot of support from champions (eg, Directors of Nursing) to overcome. Clinicians likewise had an adjustment period to get used to a more team-based approach that involved the virtual Avera clinical team members. However, it was somewhat easier to get clinician buy-in because the pilot could reduce their after-hours phone calls and after-hours decision making related to patient transfers. Avera's previous experience in other telemedicine services lines regarding the cultural adoption of technology accelerated the eLTC pilot implementation process. Internal quality improvement staff surveys conducted during the pilot showed nursing staff generally believed eLTC improved the quality of their patient's care and positively impacted their workload, and more staff agreed with these perceptions as the pilot progressed.

One remaining challenge in this project phase was that nearly 50% of the time, eLTC staff believed that they were contacted too late in disease processes to safely treat the resident in place, thus, necessitating a transfer. Often, by the time the Avera eLTC providers received an urgent care call from an LTC facility for a patient with a urinary tract infection, cellulitis, or pneumonia, the patient was already septic and staff were not able to prevent a transfer. Earlier and more comprehensive interventions will be needed to fully reach this program's potential in the future.

Conclusions

Overall, the eLTC pilot showed promise as a proof-of-concept. Avera was able to create practical procedures about eLTC design and implementation that resulted in increasing utilization and promising reductions in unnecessary transfers to emergency departments and hospitalizations. LTC staff satisfaction was also encouraging, though there remains room for improvement. For example, as a result of lessons learned in this pilot, the eLTC team is taking a more comprehensive geriatric approach and including more support around transitions of care and more holistic involvement in facility quality improvement efforts and local LTC staff training and empowerment. Avera is also focusing on patient and family involvement and engagement in the process, as well as more robust staff and family feedback, including gathering information on resident and family perceptions on the utility of eLTC. In 2012, the eLTC pilot served fewer than 400 residents; however, as of mid-2016, eLTC has enrolled over 5000 residents in the program across 34 sites at part of multimillion dollar scale- up project funded by the federal government. eLTC promotes a culture of safely treating patients in place, and avoiding medically unnecessary transfers that result in improving the quality of resident's health and well-being, as well as offering concomitant cost-savings. The Avera eLTC team will continue to rigorously study resident outcomes, family perspectives, staff and provider experiences, and costs on an ongoing basis. Study findings will provide valuable information for policymakers, providers, and other rural stakeholders who are interested in implementing a similar model in their rural communities.

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Appendix B: Analysis of Avera eLTC CMMI Health Care Innovation Award Round 2 Savings to Medicare

Total Medicare Cost of Care Per Beneficiary Per Month Impact

As an HCIA 2 recipient, Avera requested Medicare claims data for beneficiaries residing in the long term care facilities served by the project. This included up to three years of claims data for residents receiving care in the facility prior to the start of eLTC services as well as claims data through the most recent quarter. Avera's Business Intelligence analysts analyzed the claims data set to determine an average monthly cost of care for residents receiving care in eLTC facilities before services began (pre) and after service initiation (post). This is an internal and preliminary analysis of the claims data to determine the difference in cost of care with the eLTC service intervention.

Key Terms and Definitions

Total Medicare Cost of Care - The total sum of all paid Medicare claims for all claim types (Inpatient, Outpatient, SNF, Hospice, Home Health, Carrier, and DMERC)

Beneficiary Attribution Period – The unique beneficiary count and total cost of care amount is calculated only for residents who are attributed to the facility and only for the duration of the time periods that the residents are attributed to the facility. The time period for each resident starts on their admission to the SNF and ends 30 days following their discharge from the SNF.

Pre/Post Period – The month that each facility went live with eLTC Services determines the pre/post period for that facility. If a facility went live with eLTC services on November 12, 2014, then November 2014 would be the first month included in the post period. In this example, November 2011 through October 2014 would be the 3 year pre period for this facility.

Medicare Claims/MDS Data Period – eLTC has Medicare claims and MDS data from January 2011 – November 2016.

Methodology Calculation

Total Medicare Cost of Care PBPM = The sum of every resident's total cost of care for every month in the defined pre/post period divided by the sum of every facility's monthly unique beneficiary count in the defined pre/post period.

*Results

The following total Medicare Cost of Care PBPM results are based on the above calculation:

Pre	Post	
3 Year Pre Go-Live	Go-Live to Date (Nov 2016)	**Difference**
$2,161.93	$1,819.54	**$342.39**

**Results are subject to change as updated claims/MDS data is made available.*

Appendix C: Performance Metric Source and Identification

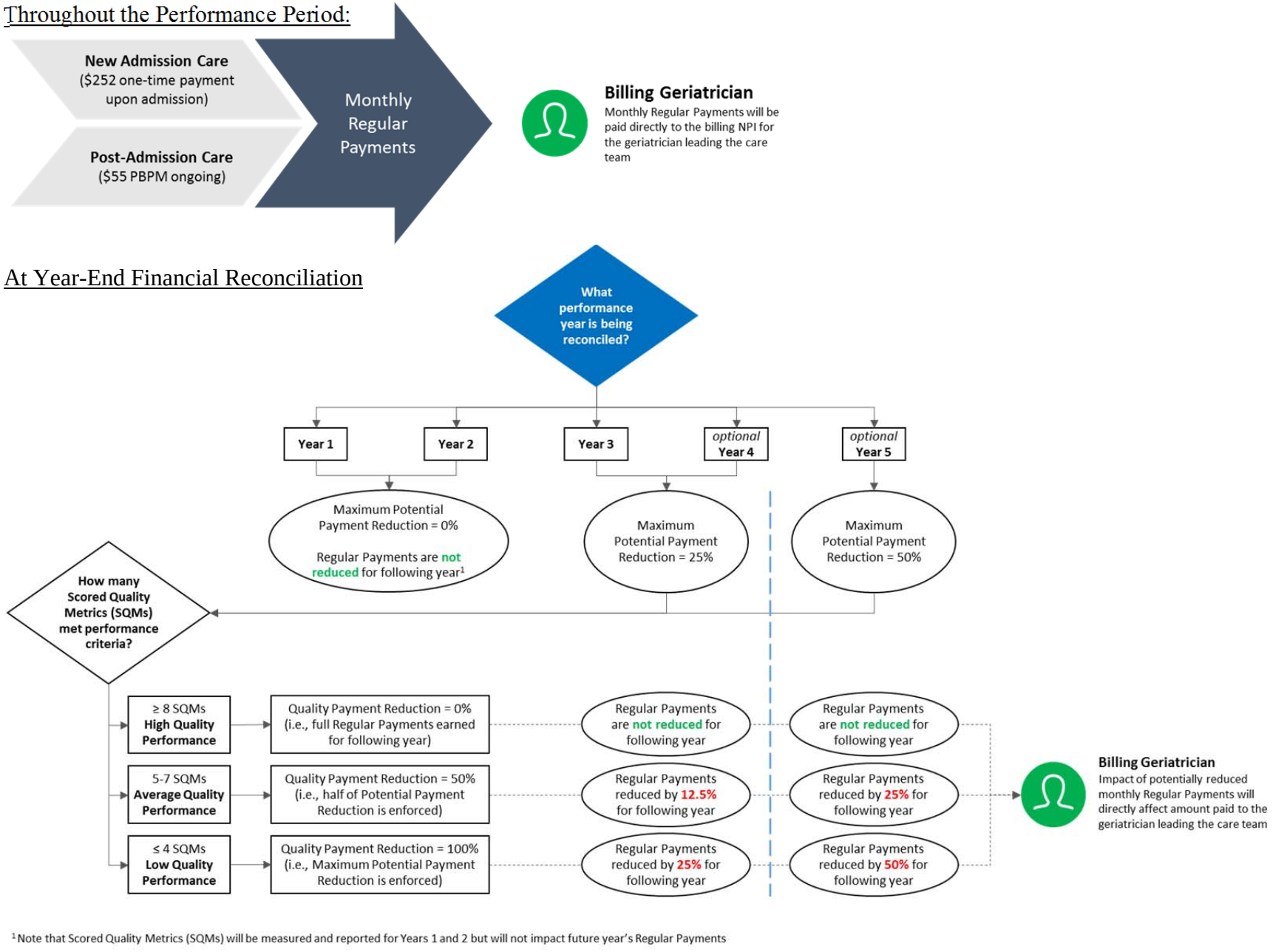
Short Stay: Health Outcome / Health Cost Management Metrics				
	Measure Description	**Source**	**ID Numbers**	**Performance Criteria**
1	Percentage of short-stay residents who have had an outpatient emergency department visit	CMS Nursing Home Compare	New measure Fall 2018	Top 2 quintiles or improve by 5% annually
2	SNF 30-day All Cause Readmission Measure	Value Based Purchasing	NQF: 2510	

Short Stay: Quality Metrics				
	Measure Description	**Source**	**ID Numbers**	**Performance Criteria**
3	Percentage of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine	CMS Nursing Home Compare	CMS: N003.02 NQF: 0680	Above the 50th percentile or improve toward the average by 5 percentile annually
4	Percentage of short-stay residents assessed and given, appropriately, the pneumococcal vaccine	CMS Nursing Home Compare	CMS: N007.01 NQF: 0682	
5	Percentage of short-stay residents who are newly administered antipsychotic medication	CMS Nursing Home Compare	CMS: N011.01 NQF: none	

Long Stay: Quality Metrics				
	Measure Description	**Source**	**ID Numbers**	**Performance Criteria**
6	Percentage of long-stay residents with a urinary tract infection	CMS Nursing Home Compare	CMS: N024.01 NQF: 00684	Above the 50th percentile or improve toward the average by 5 percentile annually
7	Percentage of long-stay residents who are administered antipsychotic medications	CMS Nursing Home Compare	CMS: N031.02 NQF: none	
8	Percentage of long-stay residents who have depressive symptoms	CMS Nursing Home Compare	CMS: N030.01 NQF: 0690	
9	Percentage of long-stay residents who received an antianxiety or hypnotic medication	CMS Nursing Home Compare	CMS: N033.01 NQF: none	
10	Percentage of long-stay residents assessed and given, appropriately, the seasonal influenza vaccine	CMS Nursing Home Compare	CMS: N016.01 NQF: 0681	

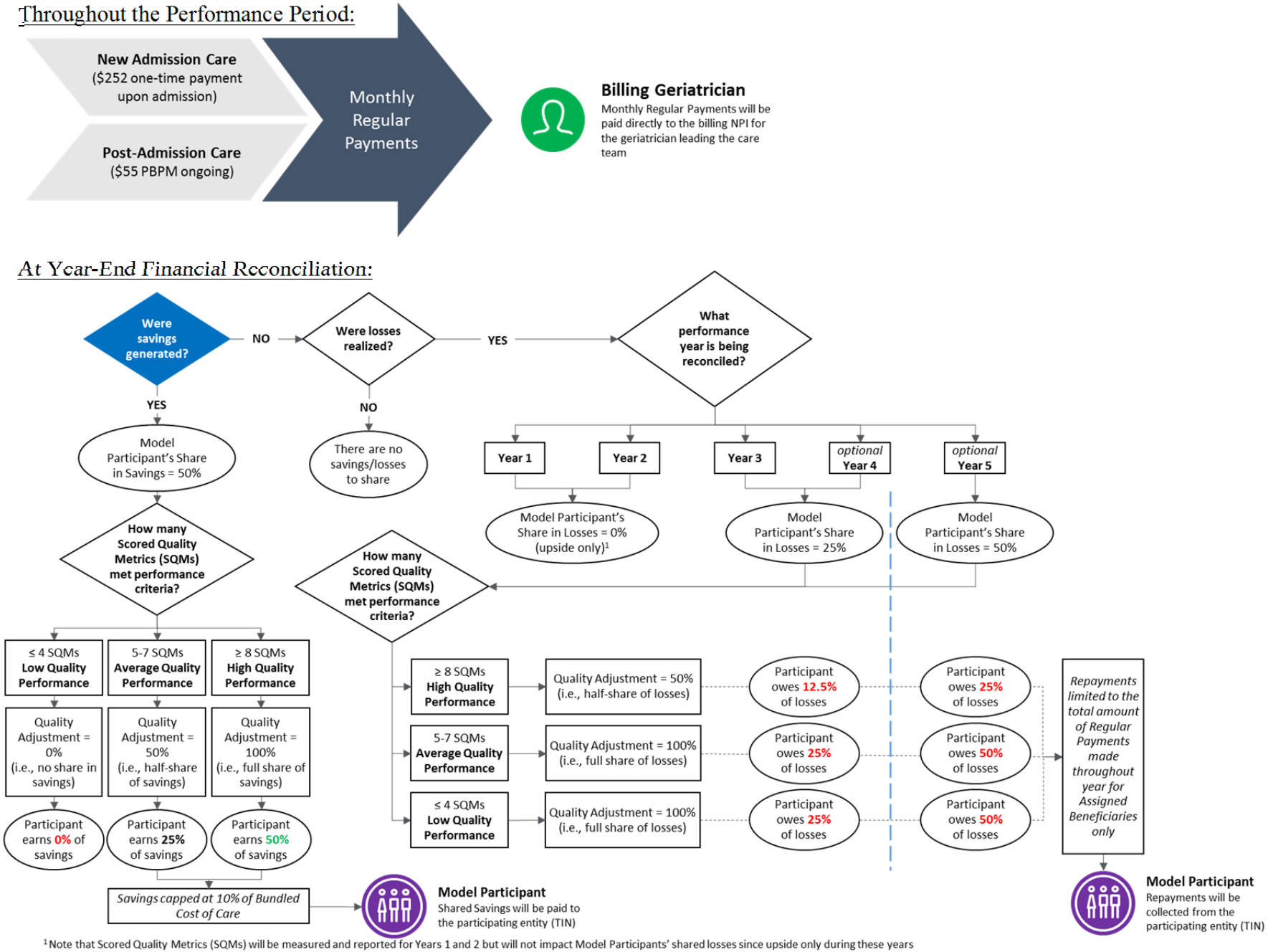
Monitored Quality Metrics				
	Measure Description	**Source**	**ID Numbers**	**Performance Criteria**
1	Percentage of short-stay residents who made improvements in function	CMS Nursing Home Compare	CMS: N037.02 NQF: none	Above the 50th percentile or not decrease more than 5 percentiles annually. Grounds for removal from the program.
2	Percentage of short-stay residents who were successfully discharged to the community	CMS Nursing Home Compare	New measure Fall 2018	
3	Percentage of short-stay residents who self-report moderate to severe pain	CMS Nursing Home Compare	CMS: N001.01 NQF: 0676	
4	Percentage of short-stay residents who have pressure ulcers that are new or worsened	CMS Nursing Home Compare	CMS: N002.02 NQF: 0678	
5	Percentage of long-stay residents whose ability to move independently worsened	CMS Nursing Home Compare	New measure Fall 2018	
6	Percentage of long-stay residents whose need for help with daily activities has increased	CMS Nursing Home Compare	CMS: N028.01 NQF: 0688	
7	Percentage of long-stay high-risk residents with pressure ulcers	CMS Nursing Home Compare	CMS: N015.01 NQF: 0679	
8	Percentage of long-stay residents who have/had a catheter inserted and left in their bladder	CMS Nursing Home Compare	CMS: N026.01 NQF: 0686	
9	Percentage of long-stay residents who were physically restrained	CMS Nursing Home Compare	CMS: N027.01 NQF: 0687	
10	Percentage of long-stay residents who self-report moderate to severe pain	CMS Nursing Home Compare	CMS: N014.01 NQF: 0677	
11	Percentage of long-stay residents experiencing one or more falls with major injury	CMS Nursing Home Compare	CMS: N013.01 NQF: 0674	
12	Percentage of long-stay low-risk residents who lose control of their bowels or bladder	CMS Nursing Home Compare	CMS: N025.01 NQF: 0685	
13	Percentage of long-stay residents who lose too much weight	CMS Nursing Home Compare	CMS: N029.01 NQF: 0689	

Appendix D: ICM SNF APM Process Flow Diagram –Performance Based Payment



[1] Note that Scored Quality Metrics (SQMs) will be measured and reported for Years 1 and 2 but will not impact future year's Regular Payments

Appendix E: ICM SNF APM Process Flow Diagram –Shared Savings Model



[1] Note that Scored Quality Metrics (SQMs) will be measured and reported for Years 1 and 2 but will not impact Model Participants' shared losses since upside only during these years

REPLY TO:

☐ 135 HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1501
(202) 224-3744
www.grassley.senate.gov

☐ 721 FEDERAL BUILDING
210 WALNUT STREET
DES MOINES, IA 50309-2106
(515) 288-1145

☐ 111 7TH AVENUE, SE, BOX 13
SUITE 6800
CEDAR RAPIDS, IA 52401-2101
(319) 363-6832

United States Senate

CHARLES E. GRASSLEY

WASHINGTON, DC 20510-1501

REPLY TO:

☐ 120 FEDERAL BUILDING
320 6TH STREET
SIOUX CITY, IA 51101-1244
(712) 233-1860

☐ 210 WATERLOO BUILDING
531 COMMERCIAL STREET
WATERLOO, IA 50701-5497
(319) 232-6657

☐ 201 WEST 2ND STREET
SUITE 720
DAVENPORT, IA 52801-1817
(563) 322-4331

☐ 307 FEDERAL BUILDING
8 SOUTH 6TH STREET
COUNCIL BLUFFS, IA 51501-4204
(712) 322-7103

June 5, 2017

Deb Fisher-Clemens
Senior Vice President
3900 West Avera Drive
Sioux Falls, South Dakota 57108-5721

Dear Ms. Fisher-Clemens:

I have contacted Thomas E. Price, M.D., Secretary of the U.S. Department of Health and Human Services, regarding the Intensive Care Management Skilled Nursing Facility Alternative Payment Model submitted by Avera Health Senior Care eLong Term Care (eLTC) to the Physician-Focused Payment Model Technical Advisory Committee. I asked that it be given all due consideration. Should I receive a response from the U.S. Department of Health and Human Services, I will relay the necessary information to you.

Thank you for allowing me to be of assistance to you. If you have any further questions regarding this, or any other federal matter, please do not hesitate to contact me again.

Sincerely,

Chuck Grassley

Charles E. Grassley
United States Senator

DEB FISCHER
NEBRASKA

COMMITTEES:
AGING
ARMED SERVICES
COMMERCE, SCIENCE, AND TRANSPORTATION
ENVIRONMENT AND PUBLIC WORKS
RULES AND ADMINISTRATION

United States Senate

WASHINGTON, DC 20510

June 7, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Technical Advisory Committee:

I write to request your full consideration for the application submitted by Avera Health Senior Care eLong Term Care (eLTC) for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model.

Avera Health is a regional partnership for health professionals, which shares support services to provide care to more than 330 locations in over 100 communities. The partnership proposes a new physician-focused payment model that leverages a board-certified geriatrician's expertise across geography, population, and clinical teams using an interactive telecommunications system for encounters. The model was designed based on the successful Avera eCARE Senior Care eLong Term Care program funded by The Center for Medicare and Medicaid Innovation.

The proposed model will provide a method of payment for organizations utilizing two-way telehealth technology to establish geriatrician-led teams providing elder care in various settings. It will greatly expand access to the services provided by board-certified geriatricians, improve the quality of health care delivered to a growing elderly population in various settings, adopts best practices, and support the local workforce.

Avera Health seeks to implement this innovative solution to positively impact patients through more timely and appropriate care, increasing quality of life and satisfaction. Facilities will also benefit from this proposal through increased quality of care, less workforce turnover, and difficulty recruiting new employees.

Thank you for your consideration of this application.

Sincerely,

Deb Fischer
United States Senator

☐**Lincoln Office**
440 North 8th Street
Suite 120
Lincoln, NE 68508
(402) 441–4600
(402) 476–8753 (Fax)

☐**Omaha Office**
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Suite 205
Omaha, NE 68154
(402) 391–3411
(402) 391–4725 (Fax)

☐**Scottsbluff Office**
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Suite F2
Scottsbluff, NE 69361
(308) 630–2329
(308) 630–2321 (Fax)

☐**Kearney Office**
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Kearney, NE 68847
(308) 234–2361
(308) 234–3684 (Fax)

☐**Norfolk Office**
Post Office Box 1021
Norfolk, NE 68702
(402) 200–8816

http://fischer.senate.gov

COLLIN C. PETERSON
7TH DISTRICT, MINNESOTA
COMMITTEE ON AGRICULTURE
RANKING MEMBER

2204 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
TELEPHONE: (202) 225-2165
FAX: (202) 225-1593
INTERNET: www.house.gov/collinpeterson

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

June 8, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear PTAC Committee:

I write to offer my support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC). If this model is approved, it will support a telehealth-based, geriatrician-led team approach to care for the elderly. This model uses two-way telehealth to increase access for elderly patients in rural areas.

It is my understanding that Avera's successful eLTC program serves as the basis for this proposal, due to its proven ability to provide both high-quality elder care and lower health care costs.

This model has potential to expand access to trained geriatricians and improve the quality of care delivered to elderly patients. In addition, the proposed model will adopt best practices in the industry and support the local workforce. Having implemented telehealth in more than 330 locations, Avera Health is well positioned to advance this proposal.

I encourage your strongest consideration of this proposal. Thank you for your time and attention to this matter.

Sincerely,

Collin C. Peterson
Member of Congress

DISTRICT OFFICES

714 LAKE AVENUE
SUITE 107
DETROIT LAKES, MN 56501
(218) 847-5056
FAX: (218) 847-5109

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MARSHALL, MN 56258
(507) 537-2299
FAX: (507) 537-2298

324 3RD STREET SW
SUITE 4
WILLMAR, MN 56201
(320) 235-1061
FAX: (320) 235-2651

STEVE KING
4TH DISTRICT, IOWA

Congress of the United States
House of Representatives
Washington, DC 20515–1504

COMMITTEES:
AGRICULTURE
CHAIRMAN
SUBCOMMITTEE ON DEPARTMENT OPERATIONS, OVERSIGHT, AND NUTRITION
JUDICIARY
POLICY
SMALL BUSINESS

June 5, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee Members:

I have received a request for assistance from Avera Center for Public Policy regarding an Avera Health Senior Care e-Long Term Care (eLTC) proposed payment model. I am aware of the benefits of telehealth in the rural and underserved areas of Iowa.

The proposed Intensive Care Management Skilled Nursing Facility Alternative Payment Model has the potential to reduce health care costs while improving quality of care for residents receiving acute and long term care.

I have been informed that the model employs two-way audio/visual telehealth technology to connect a limited number of geriatric doctors to an increased population of elderly patients in various locations.

Access to adequate health care is a crucial need in Iowa and this proposal can improve the quality of care received by patients. For this reason, I appreciate your full and fair consideration of this proposal.

Thank you for your attention to this important matter.

Sincerely,

Steve King

Steve King
Member of Congress

SK\sh

AMES OFFICE
1421 S. BELL AVENUE, SUITE 102
AMES, IA 50010
(515) 232–2885
FAX: (515) 232–2844

FORT DODGE OFFICE
723 CENTRAL AVENUE
FORT DODGE, IA 50501
(515) 573–2738
FAX: (515) 576–7141

MASON CITY OFFICE
202 1ST STREET SE, SUITE 126
MASON CITY, IA 50401
(641) 201–1624
FAX: (641) 201–1523

HTTP://WWW.STEVEKING.HOUSE.GOV

SIOUX CITY OFFICE
526 NEBRASKA STREET
SIOUX CITY, IA 51101
(712) 224–4692
FAX: (712) 224–4693

SPENCER OFFICE
P.O. BOX 650
SPENCER, IA 51301
(712) 580–7754
FAX: (712) 580–3354

WASHINGTON, D.C. OFFICE
2210 RAYBURN
WASHINGTON, D.C. 20515
(202) 225–4426
FAX: (202) 225–3193

May 15, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/) U.S. DHHS Asst. Secretary for Planning and Evaluation
Office of Health Policy
200 Independence Ave. S.W.
Washington DC 20201
PTAC@hhs.gov

SUBJECT: Avera Health Letter of Intent re. Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model (ICM SNF APM)

Dear Committee Members:

I am writing on behalf of Avera Health's request to enter into a Letter of Intent regarding the above focus (ICM SNF APM) review. As President and CEO of The Evangelical Lutheran Good Samaritan Society (the Society) I want to offer our support to Avera Health's request.

The Society has skilled nursing facilities throughout the country and is the nation's largest not-for-profit provider of long-term care services. We have partnered with Avera Health in their Virtual Care Center for the Centers for Medicare and Medicaid Innovation project since its inception. As a partner with Avera, we have experienced numerous benefits of the Alternative Payment Model – which has included lower costs, more effective response to patients' needs in our rural SNFs, as well as reduced readmission rates among our participating facilities.

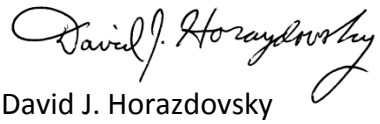
For your reference, I have attached a letter from John F. Porter, President and CEO of Avera Health, that further explains background and detail of their application.

The Society is enthused to support Avera Health's application to enter into this Letter of Intent. We strongly recommend your favorable consideration to the proposal.

Should you have any questions related of the Society's support and recommendation, please contact Dr. Victoria Walker, as follows:

Victoria Walker MD, CMD, FAAFP
Chief Medical and Quality Officer
The Evangelical Lutheran Good Samaritan Society
2014-16 APSA Congressional Health and Aging Policy Fellow
605-362-3314 (Office) / 605-214-7301 (mobile)
Vwalker3@good-sam.com

Sincerely,



David J. Horazdovsky
President and CEO

Attachment

17410 College Parkway, Suite 200
Livonia, MI 48152
tel 734-542-8300
TrinityHealthSeniorCommunities.org

June 13, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

On behalf of Trinity Health, I'd like to express strong support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model submitted by Avera Health Senior Care eLong Term Care (eLTC). The cornerstone for this proposal is the eLTC program, which delivers improved quality of care to older adult patients, better health outcomes and reduced healthcare costs.

If approved and implemented, the proposed model will provide payment to organizations when two-way audio/visual telehealth technology is used to establish geriatrician-led care teams. Of particular benefit, the model will increase access by connecting geriatricians and their interdisciplinary care teams with a significant number of older adult patients in both urban and rural settings.

Trinity Health is well known for its commitment to the country's aging population. Our organization is the innovator of Senior Emergency Departments and the nation's largest nonprofit provider of home health care services in terms of number of visits. Trinity Health is also the nation's leading provider of PACE (Program of All Inclusive Care for the Elderly) based on the number of programs available. The Intensive Care Management Skilled Nursing Facility Alternative Payment Model is consistent with Trinity Health's commitment to older adult patients. Furthermore, this model stands alongside our mission to be a compassionate and transforming healing presence within our communities.

I fully support this proposal and look forward to monitoring its progress. Thank you for your consideration.

Sincerely,

Steven Stein, MD, MHS
Chief Medical Officer
Trinity Health Continuing Care

WELCOV
HEALTHCARE

June 6, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

It has come to my attention that Avera Health Senior Care eLong Term Care (eLTC) has submitted a proposed payment model for your review. As an advocate of specialized health care services for the elderly, I write in strong support of this proposal, the Intensive Care Management Skilled Nursing Facility Alternative Payment Model.

Avera's eLTC program represents the foundation of this proposal. Developed in 2014, Avera eLTC reduces healthcare costs and improves care for residents of acute care and long term care facilities through the use of two-way telehealth equipment. The proposed payment model will provide reimbursement to Avera eLTC services provided in urban and rural acute care and long term care facilities. If the model is accepted, other entities can replicate its services to receive reimbursement when telehealth technology is used to implement a geriatrician-led care team.

In my current role at Welcov Healthcare, I serve as Chief Operating Officer. The mission of Welcov Healthcare is to exceed customer expectations through genuine quality care, innovative services and positive operational outcomes. Very much in step with our mission, the Intensive Care Management Skilled Nursing Facility Alternative Payment Model includes a variety of services provided by a geriatrician-led interdisciplinary care team. Because care for the elderly involves vulnerable individuals who are often underserved, I commend Avera for their commitment to providing increased patient access through innovation.

I fully support this proposal and the efforts brought forth by these dedicated individuals. Thank you for your consideration.

Sincerely,

Jeffrey R. Amann, COO
Welcov Healthcare

Blackhills
HEALTHCARE

June 2, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

I am writing in support of the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC). It is my understanding that this proposal is based on Avera's eLTC program, which has shown great success in delivering enhanced levels of care to elderly patients while simultaneously reducing healthcare costs.

Upon approval, the proposed model will provide payment for organizations utilizing two-way telehealth to set up care teams led by a board-certified geriatrician.

My organization, Skyline Healthcare, aims to provide superior, specialized healthcare to elders. With that in mind, I am particularly encouraged in the potential of this model to connect geriatricians to a large population of elderly patients, whether they be located in rural or urban areas. I also envision fewer unnecessary medical transfers and reduced hospital emergency department visits and readmissions, which will promote healing, comfort and enhanced quality of life for elderly residents.

I fully support this innovative payment model and appreciate your thorough review.

Thank you for your time and attention to this matter.

Sincerely,

Dixie Wilde

Dixie Wilde
DVP of Operations- SD
Skyline Healthcare, LLC

Department of Veterans Affairs
Michael J. Fitzmaurice South Dakota Veterans Home
2500 Minnekahta Avenue
Hot Springs, SD 57747
Phone 605.745.5127
Fax 605.745.5547

May 24, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

On behalf of the Michael J. Fitzmaurice State Veterans Home in Hot Springs, S.D., I would like to express my support for the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC).

The goals of the State Veterans Home include operating with efficiency, innovation and adaptability to honor and serve South Dakota's military veterans and their spouses. The eLTC program helps realize these goals through reduced healthcare costs and improved quality of resident care.

The eLTC program serves as the basis of the proposed payment model. If approved and implemented, the Intensive Care Management Skilled Nursing Facility Alternative Payment Model will provide payment for organizations delivering geriatrician-led interdisciplinary care via two-way audio/visual telehealth. In addition, a greater number of elderly patients who are often underserved will gain access to the expertise of a board-certified geriatrician and geriatric team.

The Michael J Fitzmaurice Veterans Home strives to consistently provide high-quality long term care with dedication and respect. As we care for America's heroes, I believe the Intensive Care Management Skilled Nursing Facility Alternative will add to the ability to provide superior care and enhanced quality of life for elderly residents.

Thank you for considering this proposal.

Sincerely,

Brad Richardson

Brad Richardson
Superintendent

NATIONAL RURAL HEALTH ASSOCIATION

May 30, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

I am writing to support the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC). This proposal is based on Avera's eLTC program, which has shown positive results in delivering enhanced care to elderly residents of long term care facilities while reducing healthcare costs.

Upon approval by this committee and CMS, the proposed model will provide payment for organizations using two-way telehealth technology to implement multidisciplinary care teams led by a board-certified geriatrician. This model is vital for expanding patient access to geriatrician services, enhances the quality of care delivered to the elderly, adopts best practices and supports the local workforce.

Healthcare providers and patients in rural areas face barriers such as workforce shortages, socioeconomic factors and health inequities. It has been my privilege to explore creative solutions to these challenges, and I believe the Intensive Care Management Skilled Nursing Facility Alternative Payment Model offers great promise in leveraging technology to bring geriatric medicine to more patients, regardless of location.

I support this innovative payment model, recognize its many benefits and appreciate your thoughtful consideration.

Sincerely,

Alan Morgan
Chief Executive Officer

600 East Capitol Avenue | Pierre, SD 57501 P605.773.3361 F605.773.5683

SOUTH DAKOTA DEPARTMENT OF HEALTH

Office of the Secretary

May 24, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee:

I am writing in support of the Intensive Care Management Skilled Nursing Facility Alternative Payment Model proposed by Avera Health Senior Care eLong Term Care (eLTC). This proposal is based on Avera's eLTC program, which has shown tremendous results in delivering enhanced care to elderly residents of long term care facilities while reducing healthcare costs.

Upon approval by this committee and CMS, the proposed model will provide payment for organizations using two-way telehealth technology to implement multidisciplinary care teams led by a board-certified geriatrician.

The South Dakota Department of Health's Office of Licensure and Certification works to ensure that state health and safety standards are met. In addition, we also review federal standards when a facility is a Medicaid or Medicare provider. Although we serve a regulatory function, our Department has long believed it better serves residents when we act in a spirit of collaboration with healthcare providers. Our experience working with facilities utilizing Avera eLTC echoes this partnership-based approach.

I fully support this innovative payment model, recognize its many benefits and appreciate your thoughtful review.

Thank you for your consideration.

Sincerely,

Kim Malsam-Rysdon

Kim Malsam-Rysdon
Secretary of Health

Iowa Department of Public Health
Protecting and Improving the Health of Iowans

Gerd W. Clabaugh, MPA
Director

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

June 13, 2017

Ms. Danielle Hamann, Director
Avera Center for Public Policy
3900 W. Avera Drive
Sioux Falls, SD 57108

Dear Ms. Hamann;

Thank you for sharing application to the Physician-Focused Technical Advisory Committee. Coordinated care is important for individuals receiving care in skilled nursing facilities. Your proposal for a model that meets the requirements for participating organizations to provide a comprehensive multidisciplinary geriatric program which includes: geriatrician-led care team, transitional care support, immediate 24/7 access to a provider for urgent/acute care diagnosis and treatment, mentoring for nurses and assistants, and quality and performance improvement would benefit elderly beneficiaries. The Avera Intensive Care Management Skilled Nursing Facility Alternative Payment Model provides the opportunity for comprehensive, patient-centered approach to health management for elderly residents through a multidisciplinary team of experts with the existing resources of a care facility through two-way telehealth and care teams led by a board-certified geriatrician.

In Iowa and around the nation there is a great need for well-developed networks and programs that function to keep health delivery systems efficient while providing the best possible care for the patients served.

We wish you the best in your submission to the Physician-Focused Payment Model Technical Advisory Committee with the U.S. Department of Health and Human Services Planning and Evaluation Office of Health Policy. The Iowa Department of Public Health looks forward to hearing the future status of this project.

Sincerely,

Dr. Bob Russell, DDS, MPH
Dental Director & Bureau Chief
Oral & Health Delivery Systems Bureau
Division of Health Promotion and Chronic Disease Prevention

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains
Quality Innovation Network

May 23, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear Committee Members:

As CEO of Great Plains Quality Innovation Network (the CMS designated Quality Innovation Network-Quality Improvement Organization serving the states of North Dakota, South Dakota, Nebraska and Kansas), I am pleased to submit this letter of support for the Avera Health Intensive Care Management in Skilled Nursing Facilities Alternative Payment Model proposal.

Overcoming the obstacles of geography, health care access and capacity is an ongoing challenge for the primarily rural and sparsely-populated states served by the Great Plains QIN. By utilizing health care information technology, this model would allow Medicaid consumers timely and convenient access to a multidisciplinary geriatric team, either in-person or via telemedicine, to receive care management, transitional care support and acute/urgent care diagnosis and treatment.

The proposed model embraces the shared goals of the Great Plains QIN including better health care, improved health, safer care and lower healthcare costs. Avera has proven the ability to achieve cost savings while maintaining high ratings or patient and staff satisfaction through the 2014 Virtual Care Center Centers for Medicare & Medicaid Innovation Round 2 Health Care Innovation Award (HCIA), which was used as a base for the current model proposal.

The three provider performance drivers identified in the proposal include building capacity, providing easy, early, routine care and proactively monitoring and intervening in care transition for chronic disease management. As partners for quality improvement and coordination of care, these drivers directly support Great Plains QIN's goals to improve health outcomes for consumers, including those facing complex health issues and multiple chronic diseases.

Sincerely,

Tina Georgy, RN, MS
Chief Executive Officer
Great Plains Quality Innovation Network

South Dakota Association of Healthcare Organizations

June 5, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

To Whom It May Concern:

Hello, I am pleased to share this letter of support on behalf of the South Dakota Association of Healthcare Organizations (SDAHO) in strong support of the proposed Intensive Care Management Skilled Nursing Facility Alternative Payment Model submitted by Avera Health Senior Care eLong Term Care (eLTC).

Avera's eLTC program represents the foundation of this proposal. Developed in 2014, Avera eLTC has achieved outstanding results, improving care for residents of acute care and long term care facilities and reducing healthcare costs through the use of two-way telehealth services.

If approved and implemented, the proposed model will provide payment for organizations delivering geriatrician-led interdisciplinary care via two-way audio/visual telehealth. This will greatly benefit elderly patients who will gain access to the expertise of a board-certified geriatrician and geriatric team.

The proposed model certainly keeps with the mission and vision of SDAHO to "advance healthy communities through a unified voice across the health care continuum and envisioning communities throughout South Dakota where all residents reach their highest potential for health." We believe the proposed alternative model is consistent with these high standards.

Thank you for your consideration.

Warm regards,

Scott A. Duke
President/CEO

3708 W. Brooks Place • Sioux Falls, SD 57106-4211 • Phone: (605) 361-2281 • Fax: (605) 361-5175 • Website: www.sdaho.org

2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525
www.stratishealth.org
info@stratishealth.org

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1-877-STRATIS (1-877-787-2847) toll-free

May 30, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Public Comment – Intensive Care Management Skilled Nursing Facility Alternative Payment Model

Dear PTAC Committee,

I am writing on behalf of Stratis Health in support of the Avera eLTC Intensive Care Management Skilled Nursing Facility APM (Alternative Payment Model).

Stratis Health is an independent non-profit quality improvement organization whose mission is to lead collaboration and innovation in health care quality and safety, and to serve as a trusted expert in facilitating improvement for people and communities. It is our privilege to serve as one of 14 federally-designated Medicare Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) for Minnesota, Michigan, and Wisconsin, through which we provide in-depth technical assistance and support to health care organizations to improve the quality of care for Medicare beneficiaries across the full continuum of care. From 2010-2016, we served as one of 62 federally-designated Health Information Technology Regional Extension Centers (HIT REC) for Minnesota and North Dakota, assisting 5,200 primary care providers and over 120 rural hospitals implement and optimize electronic health records. In addition, Stratis Health has a portfolio of health care improvement initiatives locally and nationally in which we are providing training, technical assistance, data analysis, convening, and support to health care organizations and health professionals to improve the quality of care delivered.

Stratis Health has a longstanding commitment to, and deep expertise in, improving quality of care and quality of life in long-term and post-acute care. We have been active in developing and supporting new models of care, including integration of technology to improve quality, so the Avera eLTC model is of interest to us. The Avera eLTC program provides the basis for the proposal, known as the Intensive Care Management Skilled Nursing Facility Alternative Payment Model. Since its beginning in 2014, eLTC is proven to reduce healthcare costs while improving the quality of care for elderly residents. eLTC ensures a more patient-centered approach for residents of long-term care facilities by wrapping a virtual, multidisciplinary team of experts around the existing resources of the long-term care facility.

If approved, the proposed model will provide payment for organizations using two-way audio/visual telehealth technology to establish geriatrician-led teams to care for elderly residents. Of particular value, the model will allow a relatively small number of geriatricians to serve a significant elderly population throughout various locations.

It is my pleasure to write in support of this proposal on behalf of Stratis Health. Thank you for your time and consideration.

Sincerely,

Jennifer P. Lundblad, PhD, MBA
President & CEO

Appendix G: List of Acronyms

ACO	Accountable Care Organizations
APM	Alternative Payment Model
BCPI	Bundled Payments for Care Improvement
CMMI	CMS Innovation Center
CMS	Centers for Medicare and Medicaid Services
CPC+	Comprehensive Primary Care Plus
EHR	Electronic Health Record
EMR	Electronic Medical Record
FFS	Fee-For-Service
HCC	Hierarchical Condition Category
HCIA	Health Care Innovation Award
HIPAA	Health Insurance Portability and Accountability Act (1996)
HITECH	Health Information Technology for Economic and Clinical Health
ICM	Intensive Care Management
ICM SNF APM	Intensive Care Management in Skilled Nursing Facility Alternative Payment Model
INTERACT	Interventions to Reduce Acute Care Transfers
LTC	Long Term Care
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MSPB	Medicare Spending Per Beneficiary
MSSP	Medicare Shared Savings Program
NF	Nursing Facility
NQF	National Quality Forum
PAH	Potentially Avoidable Hospitalizations
PBPM	Per Beneficiary Per Month
PCP	Primary Care Provider/Physician
PTAC	Physician-Focused Payment Model Technical Advisory Committee
SNF	Skilled Nursing Facility