

REMINGTON REPORT®

Business Intelligence, Insights, and Trends

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- Discharge Planning Changes
- Physicians Payments for Caregiver Training
- Future Bundled Payments and Care Transitions

VOLUME 31 ♦ ISSUE 5

Capturing Care Continuum Changes to Better Manage the Patient's Entire Care Journey

How Better Communications, Policies, and
Regulations are Un-Siloing Care Delivery

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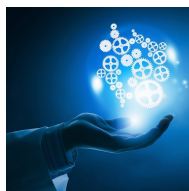
In this issue, we capture changes occurring across the care continuum. Healthcare policy, communications, and regulations are working at un-siloing care delivery amongst providers. We are at the tip of the iceberg of better managing a patient's entire care journey.



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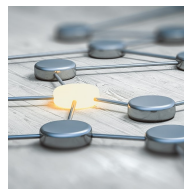
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The eight-year Guiding an Improved Dementia Experience Model (GUIDE) seeks to keep Medicare enrollees outside of long-term care facilities by extending a package of local care coordination and management and caregiver education and support services.



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Message From Lisa Remington



Lisa Remington
President, Remington's Care Continuum
Think Tank and
Publisher, The Remington Report

In this issue of The Remington Report, we capture changes occurring across the care continuum. Healthcare policy, communications, and regulations are working at un-siloing care delivery amongst providers. We are at the beginning of better managing a patient's entire care journey.

Hospitals, health systems, ACOs, payers, physicians, and insurers are adopting care delivery maturity models. The concept is "managing the whole person." The model recognizes that success requires an integrated care management model that leverages multidisciplinary teams equipped with actionable insights to provide the most effective support to patients. This creates a healthcare ecosystem centered on the patient.

What does this mean for the existing vs. future healthcare system? The key words are "un-siloing" communications, policies, and regulations to support shared decision-making to help realize the best achievable outcomes through equitable, comprehensive, high-quality, affordable longitudinal care.

As the constant unraveling of our current healthcare delivery system occurs, The [Remington Report magazine](#) and the [Remington Care Continuum Think Tank](#) will guide organizations and navigate the changes to keep all providers informed about the changes and opportunities that support healthcare's transformation to a more unified system of care.

Keep informed about critical changes presented in this issue.

- Discharge planning to unite hospitals and post-acute providers.
- What is changing about proposed physician payments to train caregivers?
- How future bundled payments support care transitions.
- Payments for social determinants and illness navigation services.





HOSPITALS

Discharge Planning: CMS Concerns About Missing Information Provided to Post-Acute Providers at Discharge

Compiled by The Remington Report Editorial Team

On June 6, 2023, CMS issued a notice that when a patient is discharged from a hospital, it is important to provide post-acute providers and caregivers as applicable with the appropriate patient information related to a patient's treatment and condition to decrease the risk of readmission or an adverse event.

For example, when a patient is discharged to a post-acute care (PAC) provider such as a skilled nursing facility (SNF) or home health agency, these providers must receive accurate and complete information related to the patient's condition and treatment (e.g., diagnoses and medications) to protect and improve the patient's health and safety.

Article Highlights

- Areas of concern for missing information at discharge planning.
- Requirements of hospital discharge planning to provide to post-acute providers.
- Impact on care transitions and readmissions.

Missing and Inaccurate Information at Discharge

CMS has identified areas of concern related to missing or inaccurate patient information when a patient is discharged from a hospital. These areas of concerns include missing or inaccurate information related to

- **Patients with serious mental illness (SMI), complex behavioral needs, and/or substance use disorder (SUD).** Information related to a patient's acute condition may be included, but information related to the patient's underlying diagnoses of SMI and/or SUD is not included. Additionally, specific treatments that were implemented to help manage these conditions while in the hospital are omitted from patient information upon hospital discharge and transfer to the PAC provider, such as additional supervision that was provided throughout the patient's hospital stay (or was provided for some of the hospital stay, but discontinued prior to discharge (e.g., 24-48 hours before discharge)).
- **Medications, such as an incomplete comprehensive list of all medications that have been prescribed to a patient during, and prior to, their hospital stay.** Common omissions also include patient diagnoses or problem lists, clinical indications, lab results, and/or clear orders for the post-discharge medication regimen. Medication information omissions have been most reported for psychotropic medications and "hard" prescriptions for narcotics (i.e., provided on paper, not electronic, as required by law).
- **Skin tears, pressure ulcers, bruising, or lacerations** (e.g., surgical site(s), skin conditions noted upon hospital admission and/or acquired during hospitalization), including orders or instructions for cultures, treatments, or dressings.
- **Durable medical equipment**, such as Trilogy, CPAP/BiPap or high-flow oxygen, which are used for respiratory treatments and skin healing equipment (e.g., example mattresses, wound vacuum machine for treatment of a variety of wounds including surgical wounds, pressure ulcers, and diabetic ulcers).
- **A patient's preferences and goals for care**, such as their choices for treatment or their advance directives for end-of-life care.
- **Communication (with PAC providers and/or caregivers) about a patient's needs at home**, or how their home environment may impact their ability to maintain their health and safety after discharge from the SNF (e.g., risk of falls, family or caregiving involvement/availability, and homelessness).

Improving Readmissions and Care Transitions

CMS indicated when the above issues occur, PAC providers are not properly prepared to care for new admissions, and caregivers are not properly prepared to care for their loved ones at home. Also, PAC providers may not be equipped or trained to care for certain conditions that apply to patients whose information they were not previously informed of by the hospital and have accepted for transfer and admission. Not only can this put the patient's health at risk, but it can also put the health and safety of other residents (in the patient's home or in a SNF), as well as provider staff, at risk.

These situations can cause avoidable readmissions, complications, and other adverse events. Finally, when an individual's preferences for end-of-life care are not known, they may receive treatments that are unnecessary or inconsistent with their wishes.

When conducting surveys, state agencies and accrediting organizations should be alert to the common issues identified above and ensure these discharges are occurring in a compliant and safe manner.

Memorandum Summary

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Below is a summary of the mem issued.

- Reminding state agencies, accrediting organizations, and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur because of an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

CMS has identified areas of concern related to missing or inaccurate patient information when a patient is discharged from a hospital.



PHYSICIANS

Future Bundled Payment Programs to Improve Care Transitions and Collaboration Across Patients' Care Journey

Compiled by The Remington Report Editorial Team

CMS is asking for feedback to create a future episode-based payment model seeking feedback regarding a potential new episode-based payment model that would be designed with a goal to improve beneficiary care and lower Medicare expenditures by reducing fragmentation and increasing care coordination across health care settings. CMS expects this episode-based payment model to be implemented no earlier than 2026, ensuring participants have sufficient time to prepare for the model.

Article Highlights

- The future expansion of bundled payment programs.
- Achieving greater participation by specialists in bundled payment programs.
- The goal of improving care transitions.
- Creating solutions across the care continuum.

In this next model, CMS is building on care improvements to better align episodic and longitudinal, population-based incentives to strengthen communication, collaboration, and coordination across providers at all points of a patient's journey through the health care system. This will be achieved through design features such as considering a shorter, 30-day episode to support coordination, while limiting overlap.



CMS Takes Lessons from Previous Bundled Payment Models

The Innovation Center is using lessons learned from their experience with the Bundled Payments for Care Improvement, Bundled Payments for Care Improvement Advanced, and the Comprehensive Care for Joint Replacement models to design and implement a new episode-based payment model focused on accountability for quality and cost, health equity, and specialty integration.

Design features such as considering a shorter, 30-day episode can support coordination, while limiting overlap

6 Fundamental Components

CMS is requesting input on a broader set of questions related to care delivery and incentive structure alignment and six foundational components:

1. Clinical Episodes
2. Participants
3. Health Equity
4. Quality Measures, Interoperability, and Multi-Payer Alignment
5. Payment Methodology and Structure
6. Model Overlap

Another goal for episode-based payment models is to:

- Improve care transitions for the beneficiary; and
- Increase engagement of specialists within value-based, accountable care.

Through this next model, CMS will build on those care improvements to better align episodic and longitudinal, population-based incentives, thereby strengthening communication, collaboration, and coordination across providers at all points of a patient's journey through the health care system. This will be achieved through design features such as considering a shorter, 30-day episode to support coordination while limiting overlap.

To help CMS ensure all accountable entities provide patients with the highest value care, the organization seeks input on the following questions:

- How can CMS structure episodes of care to increase specialty and primary care integration and improve patient experience and clinical outcomes?
- How can CMS support providers who may be required to participate in this episode-based payment model?
- How can CMS ensure patient choice and rights will not be compromised as they transition between health care settings and providers?
- How can CMS promote person-centered care in episodes, which includes mental health, behavioral health, and non-medical determinants of health?
- How can CMS support multi-payer alignment for providers and suppliers in episode-based and population-based models?
- For population-based entities currently engaging specialists in episodic care management, what are the key factors driving improvements in cost, quality, and outcomes?
- How does the nature of the relationship (that is, employment, affiliation, etc.) between a population-based entity and a specialist influence integration?
- What should CMS consider in the design of this model to effectively incorporate health information technology (health IT) standards and functionality, including interoperability, to support the aims of the model?

- How can CMS include home and community-based interventions during episode care transitions that provide connections to primary care or behavioral health and support patient independence in home and community settings?

Which Organizations are Using Bundled Payment Models?

Centers for Medicare and Medicaid Services

CMS is currently testing a variety of bundled payment models for providers caring for Medicare fee-for-service beneficiaries. The types of episodes included in CMS's bundled payment models span surgical procedures and medical care, including oncology. As of early 2023, provider participation in most CMS models is voluntary rather than mandatory

Medicare Advantage Organizations (MAOs)

MAOs use bundled payments for in-network providers caring for members enrolled in their Medicare Advantage products. A provider's participation in an MAO's bundled payment arrangement is typically voluntary. Because of the similarities in the demographics of individuals covered under Medicare fee-for-service and Medicare Advantage, MAOs may use CMS's episode specifications as a starting point for how their bundled payment arrangements define an episode of care.

Commercial Health Plans

Commercial health plans use bundled payments for in-network providers caring for members enrolled in their commercial products (e.g., individual and group, fully insured and self-insured). Provider participation in a commercial health plan's bundled payment arrangement is typically voluntary.

Medicaid organizations

Some state Medicaid agencies have implemented bundled payments for providers caring for Medicaid beneficiaries and/or members enrolled in a plan offered by a Medicaid managed care organization. For example, Arkansas, Ohio, and Tennessee have each developed programs requiring providers to participate in bundled payments spanning multiple specialty categories, and Colorado⁵ has developed a voluntary program focused on maternity episodes.

Request for comments in the Federal Register ([request PDF](#)).





LEGAL

Judge Orders State to Provide Private Duty Nursing Care

By Elizabeth E. Hogue, Attorney

The Court was clear that the Medicaid program must meet the needs of children for private duty care at home to prevent unnecessary or threatened institutionalization.

On July 14, 2023, a Judge issued an opinion and order, in which he said that the State of Florida must provide services, including private duty nursing care, to medically fragile children who are living in nursing homes or threatened with institutionalization so that they can live at home[United States of America v. State of Florida, Case No. 12-cv-60460-MIDDLEBROOKS/Hunt, (U.S. District Court for the Southern District of Florida, July 14, 2023)]. This court decision is based on violations of the Americans with Disabilities Act (ADA) and *Olmstead v. A.C. ex rel. Zimring*

Article Highlights

- Judge orders private duty to be provided. Similar cases are pending.
- Medicaid program must meet the needs of children for private duty care at home to prevent unnecessary or threatened institutionalization.
- Private duty agencies should prepare for an influx of clients/patients.

[527 U.S. 581 (1999)], a decision of the U.S. Supreme Court. This decision is important for home care providers because, as a result, a substantial number of additional children may receive private duty nursing care at home. Similar cases are pending in other states.

The children at issue in this case are under 21 years old and have disabilities resulting in their need for services daily. The children frequently qualify for Medicaid and require help with activities of daily living. Necessary services often include the use of technology or equipment for communication, mobility, breathing, eating, and other tasks along with the use and maintenance of feeding tubes, breathing tubes, ventilators, and wheelchairs.

Private duty agencies should take the initiative to partner with state Medicaid programs to meet the needs of an increasing number of children for private duty services at home.

Children who are institutionalized spend months and sometimes years isolated from family and the outside world. In this case, 140 children were living in nursing homes already and approximately one thousand eight hundred children were threatened with institutionalization.

The Court Said

“They don’t need to be there. I am convinced of this after listening to the evidence, hearing from the experts, and touring one of these facilities myself. If provided adequate services, most of these children could thrive in their own homes, nurtured by their own families.”

Then the Court Said

“Several Medicaid services were put at issue, but there is little question that the shortfalls in meeting the need for private duty nursing (or “PDN”) was at the heart of this case – the subject was addressed by nearly every witness who took the stand. The lack of access to PDN was by far the most glaring and critical problem facing families with medically complex children. Most families are receiving nowhere near the number of hours they require. By the close of the evidence, I was convinced that the deficit of PDN in Florida is causing systemic institutionalization.”

What the Court Said is a Lack of Services

The Court then acknowledged that the problem of the lack of adequate PDN services is likely based on staffing shortages. However, the Court refused to accept lack of staffing as a reason to not provide the services children need. The Court noted that many private duty staff members are paid \$14 per hour on average nationally. The Court observed that increasing wages may result in appropriate availability of staff members. Regardless of the cause, however, the Court was clear that the Medicaid program must meet the needs of children for private duty care at home to prevent unnecessary or threatened institutionalization.

Courts in other states are likely to issue decisions like this one. This means that private duty agencies must prepare for an influx of clients/patients. In fact, private duty agencies should take the initiative to partner with state Medicaid programs to meet the needs of an increasing number of children for private duty services at home.

The Judge quoted Nelson Mandela in the Conclusion of his opinion: "There can be no keener revelation of a society's soul than the way in which it treats its children." We can only say, "Amen!"

More on the Ruling

U.S. District Judge Donald Middlebrooks issued the ruling.

"Those who are institutionalized are spending months, and sometimes years of their youth isolated from family and the outside world. They don't need to be there.

I am convinced of this after listening to the evidence, hearing from the experts, and touring one of these facilities myself. If provided adequate services, most of these children could thrive in their own homes, nurtured by their own families. Or if not at home, then in some other community-based setting that would support their psychological and emotional health, while also attending to their physical needs."

Middlebrooks wrote that the Americans with Disabilities Act requires the state to provide services in the most "integrated setting appropriate" to meet the needs of people with disabilities. He also cited a major 1999 U.S. Supreme Court ruling that said "undue institutionalization" of people with disabilities is a form of discrimination.

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PHYSICIANS

CMS Proposes Payment to Physicians to Train Caregivers

Compiled by The Remington Report Editorial Team

For CY 2024, CMS proposes paying physicians for Caregiving Training Services. CMS proposes that payment may be made for CTS services when the treating practitioner identifies a need to involve and train one or more caregivers to assist the patient in carrying out a patient-centered treatment plan. The CTS services are furnished outside the patient's presence. The treating practitioner must obtain the patient's (or representative's) consent for the caregiver to receive the CTS. We further propose that the identified need for CTS and the patient's (or representative's) consent for one or more specific caregivers to receive CTS must be documented in the patient's medical record.

Article Highlights

- What are Caregiving Training Services (CTS)?
- What is the definition of a caregiver?
- Which patients benefit from Caregiving Service Training?
- What are the criteria for receiving payment as a caregiver?

The Caregiving Training Services must be congruent with the treatment plan and designed to effectuate the desired patient outcomes. CMS believes this is especially the case in medical treatment scenarios where assistance by the caregiver receiving the CTS is necessary to ensure a successful treatment outcome for the patient – for example, when the patient cannot follow through with the treatment plan for themselves (see examples in the section under “Which Patients Benefit from Care Involving Caregivers”).

How is a “Caregiver” Defined?

CMS broadly defines a caregiver as a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition. CMS believes a caregiver is an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technology activities at home; and helping to navigate the patient's transitions between care settings.

CMS includes a guardian in this definition when warranted. For CTS, “caregiver” also refers to guardians, who for purposes of CTS, are the caregiver for minor children or other individuals who are not legally independent. In these circumstances, a caregiver is a layperson assisting the patient in carrying out a treatment plan that is established for the patient by the treating physician or practitioner and assists the patient with aspects of their care, including interventions or other activities related to a treatment plan

established for the patient to address a diagnosed illness or injury.

The treating practitioner would train caregivers in strategies and specific activities that improve symptoms, functioning, and adherence to treatment related to the patient's primary clinical diagnoses. Caregiver understanding and competence in assisting and implementing these interventions and activities from the treating practitioner is critical for patients with functional limitations resulting from various conditions.

Which Patients Benefit from Care Involving Caregivers?

CMS believes that a patient-centered treatment plan should appropriately account for clinical circumstances where the treating practitioner believes the involvement of a caregiver is necessary to ensure a successful outcome for the patient and where, as appropriate, the patient agrees to caregiver involvement.

There may be clinical circumstances when it might be appropriate for the physician or practitioner to directly involve the caregiver in developing and carrying out a treatment plan. Such clinical circumstances could include various physical and behavioral health conditions and circumstances under which CTS may be reasonable and necessary to train a caregiver who assists in carrying out a treatment plan. Conditions include but are not limited to stroke, traumatic brain injury, various forms of dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids.

Another example, patients with dementia, autism spectrum disorder, or individuals with other intellectual or cognitive disabilities may require assistance with challenging behaviors in order to carry out a treatment plan, patients with mobility issues may need help with safe transfers in the home to avoid post-operative complications, patients with persistent delirium may require guidance with medication management, patients with certain degenerative conditions or those recovering from stroke may need assistance with feeding or swallowing.



How the Caregiver Payment Will Work

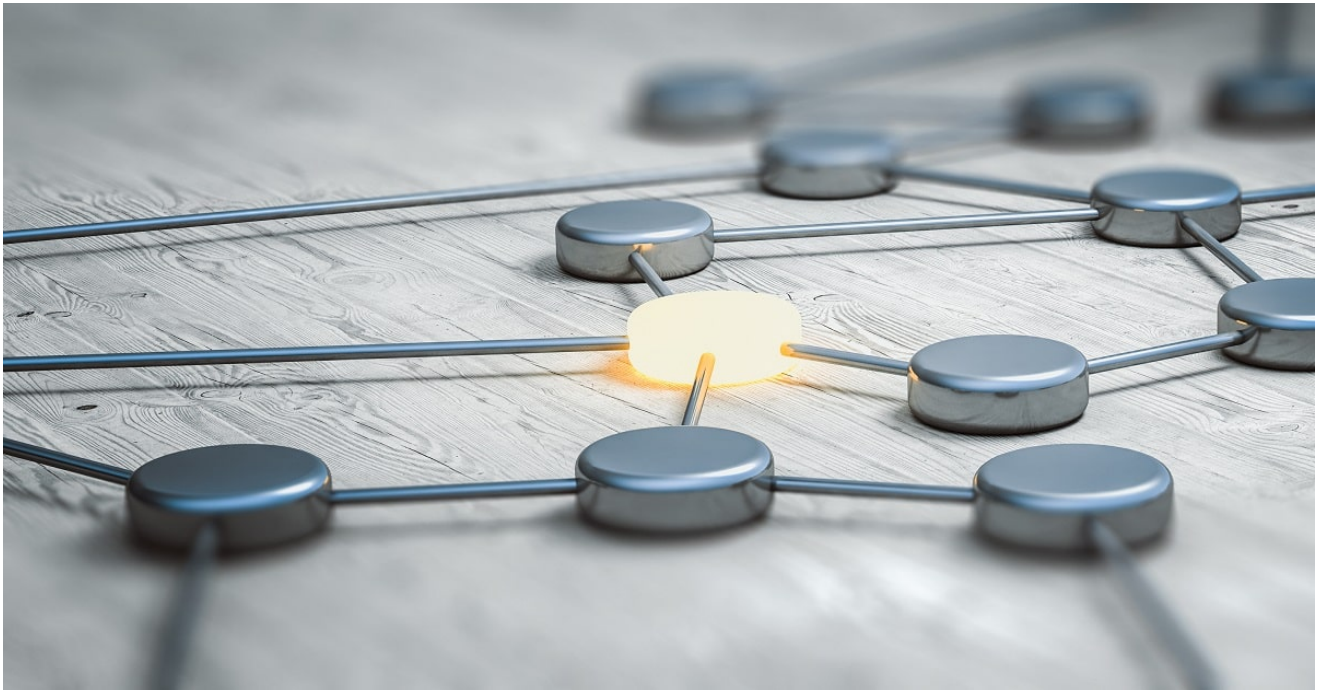
Separate from medical circumstances, CMS seeks to avoid potentially duplicative payment. They would not expect the caregiver population receiving these services on behalf of the patient to also receive CTS on behalf of the patient under another Medicare benefit category or Federal program.

When Medicare and Medicaid cover the same services for patients eligible for both programs, Medicare generally is the primary payer in accordance with section 1902(a)(25) of the Act. Based on the specificity of the coding, CMS does not expect that CTS will neatly overlap with any other coverage for patients who are dually eligible for Medicare and Medicaid.

CPT Codes Associated with Caregiver Training Services

In the code descriptors, (CPT codes 96202 and 96203 (caregiver behavior management/modification training services) and CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a PT, OT, SLP), treating practitioners may train caregivers in a group setting with other caregivers who are involved in care for patients with similar needs for assistance to carry out a treatment plan. Training for all the caregivers for the patient could occur simultaneously, and the applicable CTS codes (CPT code 96202, 96203, and 9X017) would be billed once per beneficiary. CMS proposes to require the full 60 minutes of time to be performed to report CPT code 96202. The add on code, CPT code 96203, may be reported once 75 minutes of total time is performed. billed considering the established treatment plan involving caregivers for the typical patient.

They are soliciting public comment on each of their proposals for CTS.



HOSPITALS

Legal: Recent Study Links Hospital Readmissions to Discharge Planning Process

By Elizabeth E. Hogue, Attorney

The study is based on eight focus groups that included nurses, physicians, discharge planning staff, and patients. It identified areas of possible change to the discharge planning process to reduce instances of unplanned hospital readmissions.

A recent study, "Discharge process challenges of an academic vascular surgery service: A qualitative study," by Elizabeth R. Doss, et al.; published in *Research in Nursing & Health* lays unexpected readmissions to hospitals squarely at the door of the discharge planning process. Although the study focused on patients who underwent vascular procedures, the problems identified likely apply to all patients discharged from acute care hospitals.

Article Highlights

- Improving discharge planning.
- The connection between discharge planning and care transitions.
- Multiple solutions to improve discharge planning.

How Can Discharge Planning Improve?

The goal of the study was to examine factors in the discharge planning process that can be improved to reduce preventable hospital readmissions. Readmissions negatively impact health outcomes and can cause additional stress for caregivers and healthcare providers.

The study is based on eight focus groups that included nurses, physicians, discharge planning staff, and patients. It identified areas of possible change to the discharge planning process to reduce instances of unplanned hospital readmissions as follows:

The goal of the study was to examine factors in the discharge planning process that can be improved to reduce preventable hospital readmissions.

- Communication deficiencies about contacts for patients who had follow-up concerns.
- Staffing shortages.
- Lack of time to properly educate staff about discharge procedures.
- Difficulties by patients with making follow-up appointments.
- Difficulties with receiving prescriptions and medications or wound care that was needed post-surgery.
- Lack of time to adequately educate both patients and family caregivers about post-operative care and to answer their questions.

Proposed Solutions

Proposed solutions included in the study include:

- Use of technology to improve communication.
- Developing tailored solutions to fix day-to-day barriers experienced by key stakeholders.
- Use of specialized coordinators. Caregiver support.
- Use of adaptive strategies outside current discharge processes.
- Multifaceted approach that incorporates standardized discharge processes.
- Informal problem-solving strategies.

The results of this study again point to the crucial role that discharge planners/case managers play in patients' recoveries. When patients are admitted to post-acute providers following discharge from hospitals without adequate preparation, patients, their families, and post-acute providers are more likely to experience adverse results. Now is the time to fix it! Read the related article, "Discharge Planning: CMS Concerns About Missing Information Provided to Post-Acute Providers at Discharge," on page 6.

Don't Miss These Additional Remington Report Resources

- [Data Point: Discharge Planning Codes Identify Where the Patient is Being Referred](#)
- [Discharge Planning Patterns: Care Transitions and Readmissions](#)

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PHYSICIANS

CMS Proposes to Pay Doctors for Social Determinants and Illness Navigation Services

Compiled by The Remington Report Editorial Team

Services Addressing Social Needs: Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services

For CY 2024, CMS proposes coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. CMS is proposing to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care.

Article Highlights

Proposed physician payments include an incredible array of new payment services.

- Paying doctors and non-physicians for social determinants of health.
- Paying for community health integration.
- Paying for principal illness navigation.
- Telehealth coaching payment.

CMS Proposes the Following Specific Codes and Descriptors

GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:

- Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating E/M visit.
 - ++Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors.
 - ++Facilitating patient-driven goal setting and establishing an action plan.
 - ++Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
 - Practitioner, Home-, and Community-Based Care Coordination.
 - ++Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregivers (if applicable).
- ++Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
 - ++Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
 - ++Facilitating access to community-based social services(e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).
 - Health education – Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s) and educating the patient on how to best participate in medical decision-making.
 - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.
 - Health care access/health system navigation.

++Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.

GXXX2 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).

CMS is proposing to pay separately for Community Health Integration, Social Determinants of Health Risk Assessment, and Principal Illness Navigation services when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care.

Community Health Integration (CHI) and Principal Illness Navigation (PIN) services involve a person-centered assessment to better understand the patient’s life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet social determinations of health (SDOH) needs.

- Community Health Integration services are to address unmet SDOH needs that affect the diagnosis and treatment of the patient’s medical problems.
- Principal Illness Navigation services are to help people with Medicare who are diagnosed with high-risk conditions (for example, mental health conditions, substance use disorder, and cancer) identify and connect with appropriate clinical and support resources. Community health workers, care navigators, peer support specialists, and other such auxiliary personnel may be employed by Community-Based Organizations (CBOs) if there is the requisite supervision by the billing practitioner for these services, like other care management services.

Telehealth Services Under the Physician Fee Schedule

For CY 2024, CMS proposes to add health and well-being coaching services to the Medicare Telehealth Services List on a temporary basis for CY 2024, and Social Determinants of Health Risk Assessments on a permanent basis.



HOME-BASED CARE

What's Changing About Dementia Care Offered in Patient's Home?

Compiled by The Remington Report's Editorial Team

The eight-year Guiding an Improved Dementia Experience Model (GUIDE) seeks to keep Medicare enrollees outside of long-term care facilities by extending a package of local care coordination and management and caregiver education and support services.

People with Alzheimer's disease and other forms of dementia end up in emergency care 1.4 million times a year, a new study from the Institute for Healthcare Policy & Innovation University of Michigan, published in JAMA Neurology, shows.

Article Highlights

- CMS's new care model for dementia care.
- Dementia care standardization includes assessments, care coordination, ongoing monitoring, and medication management.
- Care services in the home to prevent or delay long-term nursing placement.
- Where people with dementia live and how they receive care depends partly on their ability to pay.

3 more Findings from the Study

1. Overall, dementia accounted for nearly 7% of all ED visits among older adults.
2. Dementia patients were twice as likely to seek emergency care for accidents and behavioral disturbances compared to patients in the same age range who did not have dementia. Researchers said behavioral issues are among the primary reasons for ER visits among dementia patients "may reflect caregiver difficulty in managing behaviors."
3. Dementia patients in the ED were twice as likely to receive antipsychotic medications than other ED patients over 65.

Most People with Dementia Do Not Live in Nursing Homes

Estimates suggest that more than four times as many people with dementia live in traditional community settings than in nursing homes and residential care (such as assisted living or personal care homes). However, more than half of nursing home residents have dementia. Among those ages 70 and older living in nursing homes in 2019, 70% had dementia, according to one recent study.

Where people with dementia live and how they receive care depends partly on their ability to pay.

- People with higher incomes who have dementia are somewhat more likely to live in residential care, which costs \$49,000 (median) per year in 2019 and is not covered by Medicare.

- People with lower incomes with dementia are likelier to live at home in the community or in nursing homes. Depending on the state, Medicaid (for those who qualify) may pay a portion of nursing home expenses, which cost \$90,000 (median) per year in 2019.

The current system of care for people with dementia can be very fragmented and siloed," CMS Administrator Chiquita Brooks-LaSure said in a speech at a meeting of the National Alzheimer's Project Act Advisory Council. "This results in poor outcomes, duplicative and depersonalized services, and severe impacts on the quality of life for caregivers, who often provide significant amounts of assistance with personal care, finances, household management, clinical coordination, and other care. Additionally, fragmented care often leads to substantial financial burden, increased caregiving demands, and physical and mental strain for those caring for someone with dementia."

The Guiding an Improved Dementia Experience (GUIDE)

The eight-year Guiding an Improved Dementia Experience Model (GUIDE) seeks to keep Medicare enrollees outside of long-term care facilities by extending a package of local care coordination and management and caregiver education and support services.

The Guiding an Improved Dementia Experience is a "first-of-its-kind initiative for CMS designed to support both those living with dementia and those caring for them," she said.

Specifically, the GUIDE Model will include a sustainable alternative payment model that offers standardized dementia care, including assessments, care coordination, ongoing monitoring, medication management, and a 24/7 support line."

The model has three main goals:

1. To improve the quality of life for people with dementia.
2. To reduce strain on their unpaid caregivers.
3. To help people remain in their homes and communities, preventing or delaying long-term nursing placement.

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3 Ways to Participate in the Model

Participants in the GUIDE Model will establish dementia care programs that provide ongoing, longitudinal care and support to people living with dementia through an interdisciplinary team.

1. If a participant can't meet the GUIDE care delivery requirements alone, they can contract with other Medicare providers/suppliers, known as "partner organizations," to meet the care delivery requirements. CMS will provide a monthly per-beneficiary payment to support a team-based collaborative care approach.

2. Among their other responsibilities, model participants will be required to screen beneficiaries for psychosocial needs and health-related social needs and help navigate them to local, community-based organizations to address these needs, according to the agency. CMS will pay model participants for respite services -- the temporary services provided to a beneficiary in their home, at an adult day center, or at a facility that can provide 24-hour care -- to give unpaid caregivers temporary breaks from their caregiving responsibilities.
3. The eight-year model will offer two tracks, one for established programs and one for new programs. Established programs must have an interdisciplinary care team (including a care navigator), use an electronic health record platform that meets the standards for certified electronic health record technology, and meet other care delivery requirements. New programs must not be operating a comprehensive community-based dementia care program at the time of model announcement and will have a 1-year pre-implementation period to establish their programs.

CMS is accepting letters of interest for the GUIDE Model through September 15, 2023, and will release a GUIDE Request for Applications for the model in Fall 2023, CMS said. The model will launch on July 1, 2024, for eight years.

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