CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 205	**Date: August 28, 2018**
	Change Request 10824

Transmittal 203, dated August 10, 2018, is being rescinded and replaced by Transmittal 205, dated, August 28, 2018, to replace the word "three" with "four" in the Summary of Changes. All other information remains the same.

SUBJECT: Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement

I. SUMMARY OF CHANGES: This Change Request (CR) provides instruction to Medicare payment contractors to implement one new benefit enhancements for program year four of the Next Generation ACO program. Claims for Care Management Home Visit Waiver shall be processed for reimbursement and paid when they meet the appropriate payment requirements as outlined in this CR. This CR also includes instructions to modify the current All Inclusive Population Based Payment (AIPBP) and Population-Based Payment (PBP) enhancements in the Next Generation ACO program, as well as modifies which Healthcare Common Procedure Coding System (HCPCS) codes providers may use to bill for the current Post-Discharge Home Visit waiver enhancement.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Demonstrations

Attachment - Demonstrations

Pub. 100-19	Transmittal: 205	Date: August 28, 2018	Change Request: 10824

Transmittal 203, dated August 10, 2018, is being rescinded and replaced by Transmittal 205, dated, August 28, 2018, to replace the word "three" with "four" in the Summary of Changes. All other information remains the same.

SUBJECT: Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

I. GENERAL INFORMATION

A. Background: The aim of the Next Generation ACO Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare Fee-for-Service (FFS). The benefit provides greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs. In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS is issuing the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the Next Generation ACO Model. An ACO may choose not to implement all or any of these benefit enhancements. Applicants will be asked questions specific to their proposed implementation of these benefit enhancements, but acceptance into the Next Generation ACO Model is not contingent upon an ACO implementing any particular benefit enhancement.

Participants in the Next Generation ACO Model are required to provide implementation information to CMS, which, upon approval, will enable the ACO's use of the optional benefit enhancements. Each optional benefit enhancement will have such an "implementation plan" requiring, for example:

(1) descriptions of the ACO's planned strategic use of the benefit enhancement;

(2) self-monitoring plans to demonstrate meaningful efforts to prevent unintended consequences; and

(3) documented authorization by the governing body to participate in the benefit enhancement.

RTI International is the specialty contractor creating the Next Generation ACO provider alignment files.

B. Policy: Section 1115A of the Social Security Act (the Act) (added by section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) authorizes the Center for Medicare & Medicaid Services (CMS) to test innovative health care payment and service delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The Next Generation ACO Model will implement design elements with implications for the FFS system for the fourth performance year that includes a benefit enhancement to give ACOs the tools to direct care and engage beneficiaries in their own care. This CR also makes slight modifications to the operations of current benefit enhancements offered by the Model.

<u>New Benefit Enhancement for 2019</u>

Care Management Home Visits

Building upon the Next Generation ACOs' experience in offering the Post-Discharge Home Visits benefit enhancement, the model will offer a new Care Management Home Visits benefit enhancement to equip the Next Generation ACOs with a new tool to provide home visits proactively and in advance of a potential hospitalization. Next Generation participants and preferred providers who have initiated a care treatment plan for aligned beneficiaries will be eligible to receive up to two Care Management Home Visits within 90 days of seeing that Next Generation participant or preferred provider. This is not a home health benefit and beneficiaries eligible to receive home health services will not be eligible for this benefit enhancement. The items and services provided as part of these care management home visits are intended to supplement, rather than substitute for, visits to a primary care provider or specialist in a traditional health care setting. As such, these home visits are not intended to be performed on an ongoing basis, nor to serve as a substitute for the Medicare home health benefit, nor as the primary mechanism to meet beneficiaries' care needs.

We will extend the conditional Medicare payment rule waiver issued under the Post-Discharge Home Visits benefit enhancement to establish the Care Management Home Visits benefit enhancement. Specifically, the scope of covered items and services under this benefit enhancement include those services and supplies that would be covered under Medicare Part B, and are furnished "incident to" the professional services of a physician or other practitioner. With the exception that CMS will waive the *direct supervision* requirement such that the services and supplies may be furnished by auxiliary personnel under the billing physician's or other billing practitioner's *general supervision.* This new Care Management Home Visits benefit enhancement will provide Next Generation participants and preferred providers greater flexibility to furnish these services within a beneficiary's home or place of residence.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10824.1	Effective January 1, 2019, contractors shall prepare their systems to process NG ACO care management home visit claims with dates of service January 1, 2019 and later.					X	X		X	STC
10824.2	CMS shall include the following data elements/fields on the provider alignment file: 1. Record Type (Indicator values identified by a single character) 1. Care Management Home Visits = Value 7					X	X		X	STC
10824.2.1	The ACO-Operational System (OS) shall send the Multi-Carrier System (MCS) the Next Generation ACO provider alignment file that's been updated to include indicator "7" for the Care Management Home Visits benefit enhancement.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10824.3	Contractors shall note that a provider can have multiple enhancements, including Care Management Home Visits.					X	X			
10824.4	The contractors shall process NG ACO claims as Care Management Home Visits claims when the benefit enhancement indicator "7" is identified on the provider alignment file.					X	X			
10824.4.1	Contractors shall add the Healthcare Common Procedure Coding System (HCPCS) G0076 - G0080 to the Medicare Summary Notice (MSN) HCPC descriptor file with the following long descriptions: G0076: Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved Center for Medicare & Medicaid Innovation (CMMI) model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0077: Limited (30 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0078: Moderate (45 minutes) care management home visit for a new patient**.** For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0079: Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0080: Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.)		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Type of Service 1 (TOS1) applies to these HCPCS									
10824.4.2	Contractors shall add HCPCS G0081 - G0085 to the MSN HCPC descriptor file with the following long descriptions: G0081: Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0082: Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0083: Moderate (45 minutes) care management home visit for an existing patient**.** For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0084: Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) G0085: Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) Type of Service 1 (TOS1) applies to these HCPCS		X			X			X	
10824.4.3	Contractors shall add HCPCS G0086 - G0087 to the MSN HCPC descriptor file with the following long descriptions: G0086: Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home,		X			X			X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	assisted living and/or nursing facility.) G0087: Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility.) Type of Service 1 (TOS1) applies to these HCPCS									
10824.4.4	Contractors shall process NG ACO Care Management Home Visits claims when this benefit enhancement is elected by the provider for the Date of Service (DOS) on the claim, when the beneficiary is aligned for the submitted claim, and has the following HCPCS codes: • G0076 • G0077 • G0078 • G0079 • G0080 • G0081 • G0082 • G0083 • G0084 • G0085 • G0086 • G0087 This shall apply to Type of Bill: 85X, Revenue (Rev) Codes: 96X, 97X, or 98X	X	X			X	X			IOCE
10824.4.5	The Shared System Maintainers (SSMs) shall consider a beneficiary aligned if the from date on the date of service on the claim is on or after the effective start date and on or before 90 days after the effective end date.					X	X		X	
10824.4.5.1	The Common Working File (CWF) shall generate an Informational Unsolicited Response (IUR) based on beneficiary file updates for Care Management Home Visits when enhancement Indicator '7' is on the claim, using guidelines in 10824.4.5 based on 90 days after the effective end date. **NOTE:** CWF is updating the existing IUR process to								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	include NG ACO benefit enhancement Indicator 7 for IUR code 7125.									
10824.4.5.1.1	Medicare contractors shall trigger claim adjustments, if necessary, based on receipt of the CWF IUR.					X	X			
10824.4.6	Medicare contractors shall apply a rate for HCPCS codes listed below: • G0076 • G0077 • G0078 • G0079 • G0080 • G0081 • G0082 • G0083 • G0084 • G0085 • G0086 • G0087 **NOTE:** The rate will be displayed in the annual Physician Fee Schedule update.	X	X			X				
10824.4.6.1	FISS shall reimburse the lesser of the billed charge or MPFS rate for CAH Method II providers billing on Type of Bill: 85X, Rev Codes: 96X, 97X, or 98X					X				
10824.4.7	Contractors shall reject or return as unprocessable a claim line with HCPCS G0076 - G0087 that do not fall on or within the effective start date and effective end date of the provider on the Next Generation ACO participant or preferred provider file with benefit enhancement indicator "7" Care Management Home Visits. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					X	X			
10824.4.7.1	Medicare contractors shall assign Claim Adjustment Reason Code (CARC) 96 (Non-covered charge(s) with Remittance Advice Remark Code (RARC) N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code CO (contractual obligation).									
10824.4.8	Contractors shall reject or return as unprocessable a claim line with HCPCS G0076 - G0087 that do not fall on or within the effective start date and effective end date and on or before 90 days after the effective end date of the beneficiary alignment. **NOTE**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.					X	X			
10824.4.8.1	Medicare contractors shall assign CARC 96 (Non-covered charge(s) with RARC N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation).	X	X							
10824.4.9	Contractors shall display the following message on all NG-ACO Care Management Home Visits claims: MSN Message 61.3 English You received this home visit service from your Next Generation Accountable Care Organization (ACO) provider. You may have been able to receive this care because of your relationship with the ACO. Ask your doctor to tell you more about your ACO. Spanish Ha recibido el servicio de visita a la casa de parte del proveedor de su nueva generación de organización responsable del cuidado de salud (ACO). Es posible que recibió esta atención a causa de su relación con la ACO. Pregúntele a su médico que le diga más sobre su ACO.		X			X	X			
10824.4.10	Contractors shall process and flag NG ACO Care Management Home Visits claims with benefit enhancement indicator “7” when this benefit enhancement is elected by the provider for the DOS on the claim, when the beneficiary is aligned for the submitted claim, and has one of the following HCPCS codes:	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• G0076 • G0077 • G0078 • G0079 • G0080 • G0081 • G0082 • G0083 • G0084 • G0085 • G0086 • G0087									
10824.4.11	CWF shall create a new reject at the claim level if the Beneficiary has a Home Health Episode present with or without the DOEBA/DOLBA and the Dates of Service with Benefit Enhancement Indicator '7' for NG ACO is during the Beneficiary 's Home Heath Episode.								X	
10824.4.11.1	Medicare contractors shall reject or return as unprocessable a claim and assign Claim Adjustment Reason Code (CARC) 96 (Non-covered charge(s) with Remittance Advice Remark Code (RARC) N83 (No appeal rights. Adjudicative decision based on the provisions of a demonstration project), along with Group Code CO (contractual obligation).	X	X							
10824.5	The Single Testing Contractor (STC) shall provide to ACO-OS the provider and beneficiary data to create the test files by September 18, 2018. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS, VDCs
10824.5.1	The ACO-OS shall provide the provider alignment and beneficiary alignment test and final files to STC on or before the week of October 16, 2018. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS, STC
10824.5.2	The Medicare Administrative Contractors (MACs)	X	X							CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	shall provide to ACO-OS the provider and beneficiary data to create the test files on or about the week of October 30, 2018. These sample beneficiaries and providers shall be provided in a single excel file using the layout of HICNs, TINs, and NPIs. The ACO-OS shall provide a template of this Excel document. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									
10824.5.3	The ACO-OS shall push the test files to the Virtual Data Centers (VDCs) on or about the week of November 27, 2018 and transmit the test files with the MACs. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS
10824.5.4	The Single Testing Contractor (STC) shall provide to ACO-OS the provider and beneficiary data to create updated test files by November 5, 2018. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS, STC, VDCs
10824.5.5	The ACO-OS shall provide to the Single Testing Contractor (STC) the provider and beneficiary data to create updated test files by November 16, 2018. The ACO-OS contacts are: Tej Ghimire: Tej.Ghimire@cms.hhs.gov and Yani Mellacheruvu: Yani.Mellacheruvu@cms.hhs.gov									CMS, STC, VDCs
10824.6	The Medicare contractors shall bypass reason code 46#7 on Type of Bill (TOB) 11X when demonstration code 74 is present.	X							X	
10824.6.1	MACs shall adjust or reprocess claims that were previously denied or rejected for 46#7 that are brought to their attention.	X								
10824.7	Contractors shall use the following messages: CARC					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Claim Adjustment Reason Code (CARC) 132 and Group Code: CO (Contractual Obligation) for all claims with the NG ACO reduction applied and no payment can be made because the calculated provider reimbursement amount is less than the cash deductible, coinsurance, and/or blood deductible amounts; FISS to create a new finalized payment reason code to be assigned.									
10824.8	The IDR shall accept the new value '7' for Care Management Home Visits.									IDR

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10824.9	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Karin Bleeg, karin.bleeg@cms.hhs.gov , Brede Eschliman, brede.eschliman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0