CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 106	**Date: July 25, 2014**
	Change Request 8792

SUBJECT: Affordable Care Act (ACA) Bundled Payments for Care Improvement (BPCI) Initiative: Provider Education Regarding New Demonstration Codes for Skilled Nursing Facility (SNF) Claims and Payment of SNF Claims for BPCI Model 2 Beneficiaries Who Have Not Met the 3-day Hospital Stay Requirement

I. SUMMARY OF CHANGES: This CR directs Medicare Administrative Contractors to engage in provider education regarding use of a demonstration code when utilizing a waiver of the 3-day hospital stay requirement for Skilled Nursing Facility claims.

EFFECTIVE DATE: October 27, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 27, 2014

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	

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 obliged 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: 106	Date: July 25, 2014	Change Request: 8792

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I. GENERAL INFORMATION

A. Background: The Affordable Care Act (ACA) provides a number of new tools and resources to help improve health care and lower health care costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare and Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative (BPCI). Section 1115A of the Social Security Act provides authority for the Center for Medicare and Medicaid Innovation (CMMI) to test the BPCI models. Model 1 Awardees began the period of performance on or after April 1, 2013; Models 2, 3, and 4 Awardees began the period of performance on or after October 1, 2013.

The BPCI models link payments for multiple services that beneficiaries receive during an episode of care. Under Model 1, the episode includes the acute inpatient hospital stay for all Medicare fee-for-service (FFS) beneficiaries admitted for all Medicare Severity Diagnosis Related Groups (MS-DRGs). Under Models 2-4, CMMI has developed 48 clinical episodes of care that BPCI Awardees may select to test. Each episode of care is composed of a family of anchor MS-DRGs, and each Model has a different set of services included in the episode. Select clinically-unrelated readmissions are excluded from these episodes on an MS-DRG basis, and select clinically-unrelated Part B services are excluded from these episodes on a principle ICD-9 diagnosis code basis. For a more complete description of each of the models, please refer to the following paragraphs.

In Model 1, the episode of care is defined as the acute inpatient hospital stay and includes all inpatient hospital services. Medicare pays the Awardee a discounted amount based on the payment rates established under the Inpatient Prospective Payment System (IPPS). For each performance year, the aggregate Part A and Part B expenditures on Model 1 beneficiaries in the 30-day period following discharge from the Model 1 hospitalization are calculated and compared to expected post-episode expenditures. If the aggregate Part A and Part B expenditures exceed the expected post-episode spending threshold by a calculated risk threshold, the Model 1 Awardee must repay Medicare for this Excess Spending Amount. All Model 1 Awardees are acute care hospitals paid under the IPPS.

In Model 2, the episode of care is defined as the acute inpatient hospital stay and post-acute care and includes physician and non-physician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); and Part B drugs. An admission to a Model 2 episode-initiating IPPS hospital, or to any IPPS hospital where the operating or attending physician is a member of a Model 2 episode-initiating physician group practice, that results in a discharge assigned to a selected MS-DRG initiates a BPCI Model 2 episode. The episode ends, at the Awardee' s selection, either 30, 60, or 90 days after discharge. Payments to providers and suppliers are made at the usual fee-for-services rates through the usual claims processing, after which on a quarterly basis,

the aggregate Medicare payments for services included in the episode are reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 2 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries in IPPS hospitals.

In Model 3, the episode of care is defined as post-acute care including physician and non-physician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; DMEPOS; and Part B drugs. The episode is initiated upon admission to or initiation of post-acute services within 30 days of discharge from an IPPS hospital for a selected MS-DRG, with the Awardee' s episode-initiating post-acute care provider (home health agency, skilled nursing facility, long term care hospital, or inpatient rehabilitation facility) or upon initiation of post-acute care at any post-acute care provider where the operating or attending physician for the hospitalization was a member of a Model 3 episode-initiating physician group practice. The episode ends, at the Awardee' s selection, either 30, 60, or 90 days after the episode is initiated. Payments to providers and suppliers are made at the usual fee-for-services rates, through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payment for the episode is reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the Awardee; any expenditures above the target price must be repaid to Medicare by the Awardee. Awardees are also liable for any Excess Spending Amount. Model 3 Awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries receiving post-acute services.

In Model 4, the episode of care is defined as the acute inpatient hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services furnished during related readmissions. A single, prospectively determined bundled payment is made to the episode-initiating hospital to encompass all services furnished to all beneficiaries with the selected MS-DRG during the inpatient stay by the hospital, physicians, and non-physician practitioners. Awardees are liable for any Readmissions Amount, the dollar amount of the aggregate Medicare payments made for a clinically related readmission of a Model 4 beneficiary at a hospital other than the episode-initiating hospital; any Opt-out Physicians Amount, the dollar amount of any fee-for-service payments made to physicians declining payment under Model 4 for services covered in an episode; and any Excess Spending Amount. Awardees can be Medicare providers or suppliers, or conveners of participating health care providers.

Medicare Providers that provide the initial care to beneficiaries in an Episode are referred to as **Episode Initiators** . Episode Initiators are generally Acute Care Hospitals paid under the IPPS (under Models 1, 2, and 4) or skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs) (under Model 3). Note that physician group practices (PGPs) are also eligible Episode Initiators under Models 2 and 3.

Awardees assuming financial risk under the BPCI models have signed a participation agreement with CMS, agreeing to BPCI model payment policies and obligating the Awardees to repay the Medicare Trust Funds any outstanding amounts owed, as determined at the end of each quarter. **Single Awardees** are those individual Medicare providers or suppliers that assume financial risk under the model and that are the sole Episode Initiator. **Awardee Conveners** are parent companies, health systems, or other organizations that assume financial risk under the model on behalf of other Episode Initiators, but may or may not be Episode Initiators themselves. Awardee Conveners may or may not be Medicare providers/suppliers themselves. Additionally, **Facilitator Conveners** are entities that serve administrative and technical assistance functions on behalf of **Designated Awardees** (which occupy roles identical to those of Single Awardees) and

Designated Awardee Conveners (which occupy roles identical to those of Awardee Conveners).

Participants in BPCI Model 2 may qualify for a waiver of the Medicare payment policy requiring a 3-day hospital stay prior to coverage of SNF services for a given beneficiary. Under current SNF payment policy, as a prerequisite for Part A coverage of " extended care" services in a SNF, section 1861(i) of the Social Security Act (the Act) requires a beneficiary to have a qualifying hospital stay of at least 3 consecutive days (counting the day of hospital admission but not the day of discharge). For SNF claims included in an episode under Model 2, CMS may waive the 3-day hospital stay requirement. This waiver is granted on a Model 2 Awardee-specific basis, in response to an Awardee' s request to use the waiver and CMS' determination that the Awardee meets all the associated requirements for waiver use.

B. Policy: This Change Request supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative by informing Medicare providers of the policies surrounding use of the 3-day stay waiver.

For Model 2 participants who qualify for use of the waiver and are granted use by CMS, the post-hospital extended care services furnished by SNFs during a Model 2 episode of care are covered under Medicare Part A in the case of Model 2 beneficiaries who are discharged from an inpatient hospital stay of less than 3 days, as long as all other coverage requirements for such services are satisfied. In order to qualify for use of the waiver, the majority of the Awardee's identified SNF partners as reported to CMS must have in effect a quality rating of 3 or more stars under the CMS 5-Star Quality Rating System, as reported on the Nursing Home Compare website, for at least 7 out of the preceding 12 months. CMS monitors the Awardee's use of this waiver to ensure that discharges to a SNF are medically appropriate and that the majority of the Model 2 beneficiaries that are discharged to a SNF after an inpatient hospital stay of less than 3 days are cared for at SNFs rated 3-stars or better.

In addition, this Change Request directs Medicare Administrative Contractors to engage in provider education regarding the waiver of the 3-day hospital stay requirement:

- When submitting claims to Medicare that require a waiver of the 3-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "62" in the Treatment Authorization Code Field. This allows Medicare Administrative Contractors to appropriately pay SNFs treating beneficiaries during Model 2 episodes.

- In order to determine if use of the demonstration code "62" is appropriate, the following circumstances must be met:

- The hospitalization must not meet the prerequisite hospital stay requirement of at least 3 consecutive days for Part A coverage of "extended care" services in a SNF. If the hospital stay would lead to covered post-acute SNF treatment in the absence of the waiver, no demonstration code should be reported by the SNF.

- Model 2 Awardee (hospital, physician group practice, or Awardee Convener) responsible for the episode-initiating hospital or physician member of the episode-initiating physician group practice has been approved by CMS to use the 3-day stay waiver for the period of time of the beneficiary's hospitalization;

- The beneficiary's discharge MS-DRG is included in a Model 2 episode selected by the episode-initiating hospital or episode-initiating physician group practice;

- The beneficiary must have been discharged from a Model 2 episode-initiating hospital or an IPPS hospital where the beneficiary was treated by a physician member of a Model 2 episode-initiating physician group practice;

- The beneficiary must have been discharged from an IPPS hospital within 30 days of the initiation of SNF services;

- Any SNF with questions about determination of the above steps should consult with the episode-initiating hospital or physician group practice to identify the Model 2 Awardee that has documentation from CMS applicable to the use of the waiver for episodes during a certain performance quarter.

The policies described above are enforced through the Medicare Administrative Contractors and the Shared Systems Maintainers, who receive quarterly updates from CMMI to ensure that use of Treatment Authorization Code 62 is appropriate. If a SNF claim does not meet the above requirements, then there shall be no waiver of the 3-day stay requirement for that SNF claim.

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	
8792.1	Medicare Administrative Contractors (MACs) shall educate providers about the use of Demonstration Code 62 in the Bundled Payment for Care Improvement Model 2 program.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8792.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	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): Adam Conway, 410-786-2455 or adam.conway@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