CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 63	**Date: February 5, 2010**
	Change Request 6771

Subject: Modification to Accommodate the Acute Care Episode (ACE) Demonstration

I. SUMMARY OF CHANGES: The Centers for Medicare and Medicaid Services (CMS) issued change request (CR) 6001 on June 27, 2008 to implement the necessary requirements for the ACE demonstration project. Under the ACE demonstration, CMS is issuing a single global payment to an institution for both the hospital and physician components of the episode of care. CR 6001 stipulated that indirect medical education (IME) and disproportionate share hospital (DSH) payments would be processed in the same manner as for non-demonstration claims but failed to specify that capital, as well as operational IME and DSH payments, would be made in this manner. Therefore, only the operational IME and operational DSH payments are currently being made as part of the global payment.

Further, claims incurred on the day of admission or discharge but at a different location prior to that admission or after that discharge are to be processed outside the demonstration as a regular fee-for-service claim.

New / Revised Material
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

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:
SECTION A: For Fiscal Intermediaries and Carriers: N/A

SECTION B: 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.

NOTE: This CR applies only to the MAC in MAC Jurisdiction 4 which covers the States of Texas,

Oklahoma, New Mexico, and Colorado. We are already funding the J4 MAC under a separate contract for the ACE demonstration.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 63	Date: February 5, 2010	Change Request: 6771

SUBJECT: Modification to Accommodate the Acute Care Episode (ACE) Demonstration

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6001 on June 27, 2008 to implement the necessary requirements for the ACE demonstration project. Under the ACE demonstration, CMS is issuing a single global payment to an institution for both the hospital and physician components of the episode of care. CR 6001 stipulated that indirect medical education (IME) and disproportionate share hospital (DSH) payments would be processed in the same manner as for non-demonstration claims but failed to specify that capital, as well as operational IME and DSH payments, would be made in this manner. Therefore, only the operational IME and operational DSH payments are currently being made as part of the global payment.

Further, claims incurred on the day of admission or discharge but at a different location prior to that admission or after that discharge are to be processed outside the demonstration as a regular fee-for-service claim. However, claims filed by the Veterans Administration (VA) do not have a place of service. Despite the absence of a place of service, VA claims shall continue to be processed in the usual manner, outside the specifications of the ACE demonstration.

B. Policy: Both capital and operational IME and DSH payments shall be included as part of the global payment under the ACE demonstration. All other systematic requirements relating to CR 6001 shall remain unchanged at this time. In addition, VA claims for services rendered during the ACE demonstration episode of care, on the day of admission or the day of discharge, shall continue to be processed in the regular manner outside the demonstration, regardless of the absence of a place of service.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6771.1	The Part A non-RHHI contractor shall ensure that **both** capital and operational IME and DSH are reported as part of the global payment under the ACE demonstration.	X					X				
6771.2	For bills submitted to CWF, the Part A non-RHHI contractor, through its shared system, shall report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the HUIP claims transaction.						X				
6771.	The CWF shall accept the information reported in the reimbursement									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
2.1	field of HUIP claims transaction, as per 6771.2.										
6771.3	The Part A non- RHHI contractor processing the institutional claim shall compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program, and other payment amounts in the value code area of the claims record as shown below. Y1 Part A Demonstration Payment This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for capital and for operating IME and DSH which are processed in the traditional manner are also not included. Y2 Part B Demonstration Payment This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied. Y3 Part B Coinsurance This is the amount of Part B coinsurance applied by the A/B MAC to this claim. For demonstration claims, this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group). Y4 Conventional Provider Payment Amount for Non-Demonstration Claims This is the amount Medicare would have paid the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for capital and operational IME and DSH. (**NOTE:** The actual payment to the hospital under the demonstration shall be equal to the dollar amounts represented by: *"Y1" + "Y2" + Operational IME + Capital IME + Operational DSH + Capital DSH minus the Part A deductible and any Part A coinsurance that might be applicable and minus "Y3," the Part B coinsurance*.)	X					X				
6771.4	If the claim is **not** from the VA and contains a missing site of service provider ID (NPI), CWF shall reject the claim back to the contractor with an error code and trailer that indicates that the site of service NPI is needed.									X	
6771.4.1	If the site of service provider ID (NPI) has not been filled in and the claim is not from the VA, then the contractor shall return the claim to the provider to re-submit the bill with the appropriate site of service provider ID (NPI) included on the claim.	X									

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	(**NOTE:** If the claim is from the VA for services rendered on the day of admission or discharge, the contractor shall process the claim in the regular fee-for-service manner.)										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
None.	CR 6001, Transmittal Pub 100-19 Demonstrations, Issued June 27, 2008

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

V. CONTACTS

Pre-Implementation Contact(s): Cynthia Mason/410-786-6680

Post-Implementation Contact(s): Cynthia Mason/410-786-6680

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:
N/A

Section B: *For Medicare Administrative Contractors (MACs)*:

NOTE: This CR applies only to the MAC in MAC Jurisdiction 4 which covers the States of Texas, Oklahoma, New Mexico, and Colorado. We are already funding the J4 MAC under a separate contract for the ACE demonstration.

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.