

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



MLN Matters® Number: SE1613

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: January 1, 2016

Related CR Transmittal #: N/A

Implementation Date: January 1, 2016

Next Generation Accountable Care Organization - Implementation

Provider Types Affected

This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by Original fee-for-service (FFS) Medicare.

Provider Action Needed

This MLN Matters Special Edition Article provides information on the NGACO Model's benefit enhancement waiver initiatives and supplemental claims processing direction. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the Next Generation ACO Model (NGACO or the Model) on January 1, 2016. The Model is the first in the next generation of ACO provider-based models that will test opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

Core principles of the Model are:

- Protecting Medicare FFS beneficiaries' freedom to seek the services and providers of their choice
- Creating a financial model with long-term sustainability
- Utilizing a prospectively set benchmark that:
 - Rewards quality
 - Rewards both attainment of and improvement in efficiency, and
 - Ultimately transitions away from updating benchmarks based on the ACO's recent expenditures
- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at

<https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.

Participants and Preferred Providers

NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next Generation Participants and Next Generation Preferred Providers. Next Generation Participants are the core providers/suppliers in the Model. Beneficiaries are aligned to the ACO through the Next Generation Participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in certain benefit enhancements. Services furnished by Preferred Providers will not be considered in alignment and Preferred Providers are not responsible for reporting quality through the ACO.

Table 5.1 Types of Providers/Suppliers and Associated Functions¹

Provider Type	Alignment	Quality Reporting Through ACO	Eligible for ACO Shared Savings	PBP	All-Inclusive PBP	Coordinated Care Reward	Telehealth	3-Day SNF Rule	Post-Discharge Home Visit
Next Generation Participant	X	X	X	X	X	X	X	X	X
Preferred Provider			X	X	X	X	X	X	X

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

¹ This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Three Benefit Enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses 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 NGACO Model. An ACO may choose not to implement all or any of these benefit enhancements.

1. 3-Day SNF Rule Waiver

CMS makes available to qualified NGACOs a waiver of the 3-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services (“swing-bed hospital”). This benefit enhancement allows beneficiaries to be admitted to qualified Next Generation ACO SNF Participants and Preferred Providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to Next Generation ACO SNF Participants and Preferred Providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

- 1) The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and
- 2) The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
 - a. Be medically stable
 - b. Have confirmed diagnoses (for example, does not have conditions that require further testing for proper diagnosis)
 - c. Not require inpatient hospital evaluation or treatment; and
 - d. Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF Participant and Preferred Providers with which they will partner in this waiver through the annual submission of Next Generation Participant and Preferred Provider lists.

Claims

Next Generation Model 3-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the Fiscal Intermediary Standard System (FISS) checks whether 1) the beneficiary is aligned to an NGACO approved to use the SNF 3-day rule waiver; 2) the SNF provider is also approved to use the waiver; and 3) the SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demo code 74 (for the NGACO Model) and indicator value 4 (for the 3-day SNF rule waiver) is placed on the claim.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

If an eligible NGACO SNF 3-day waiver claim includes demo code 62 (for the BPCI Model 2 SNF 3-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF 3-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying 3-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF 3-day rule waiver claim questions, CMS instructed the FISS and the Multi Carrier System (MCS) maintainers to create screens. The FISS maintainer created a Sub-menu of the 6Q – CMS Demonstrations Screen to allow for inquiry of both the NGACO Provider File Data and the NGACO Beneficiary File Data. The screen shows the following data value for this waiver: 3 Day SNF Waiver = Value 4. The MCS maintainer created two screens to allow for SNF 3-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

Telehealth Expansion

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by Next Generation ACO Participants or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Claims

For those telehealth services originating at the beneficiary's home (in a rural or non-rural geographic setting) place of service (POS) code 12 (home) must be added to the claim.

Claims will *not* be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. Healthcare Common Procedure Coding System (HCPCS) codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days. Current Procedural Terminology (CPT) codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days. CPT codes 99307-99310.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

3. Post-Discharge Home Visits

CMS makes available to qualified NGACOs waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of Next Generation Participants or Preferred Providers.

Licensed clinicians, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A Participant or Preferred Provider may contract with licensed clinicians to provide this service and the service is billed by the Participant or Preferred Provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, Critical Access Hospitals (CAHs), SNFs, Inpatient Rehabilitation Facilities (IRFs) and will be limited to no more than one visit in the first 10 days following discharge and no more than one visit in the subsequent 20 days. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.

Claims

Post-discharge home visit service waiver claims must contain one of the following Evaluation and Management (E/M) Healthcare Common Procedure Coding System (HCPCS) codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>.

Additional information about the Next Generation ACO Model is available at: <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.